Grand Forks fax: 701-772-8161

VALLEY VISION CLINIC LTD.

EXCELLENCE, EXPERIENCE, COMPLETE CARE!

Patient Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I authorize the disclosure and use of health information as described below:
(Patient information and recipient information must be completed)

I. Person/Facility Providing Information

_____
Name

_____
Address

_____
City, State, Zip Code

II. Person/Facility Receiving Information

_____
Name

_____
Address

_____
City, State, Zip Code

III. The purpose for which this information may be disclosed:
○ Treatment ○ Payment ○ Coordination of care ○ Per Patient Request
○ Other _____

IV: What information may be disclosed:
○ Last two years of records
○ Appointment information
○ Behavioral (Mental/Chemical) Health
○ Lab results from _____ to _____
○ X-ray and/or imaging results from _____ to _____
○ Consultation reports from (please supply doctor's name) _____
○ Other (as described here) _____
○ **ALL OF THE ABOVE**

V. This authorization expires on the following date, event, or condition: _____
(Expires in twelve (12) months from the date, event, or condition unless specified.)

I understand that:

- I may revoke this authorization at any time by notifying, in writing, the facility listed above.
- Revoking this authorization does not apply for information that has already been released under this authorization.
- I have the right to inspect or copy the health information to be disclosed.
- If the disclosed information goes to a health care provider or health plan covered by federal privacy laws, federal privacy laws will protect it.
- Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form. Payment for services is not contingent upon me signing this form, unless those services are for the sole purpose of creating personal information for a third-party, such as life insurance companies.
- A copy of this release may be used as the original form.

_____ _____
Signature of Patient or Legal Representative *Date*

If signed by legal representative:

_____ _____
Print name of representative Relationship to patient

FOR INTERNAL USE ONLY:
Records completed by: _____ Date: _____