☐ **Valle Vista Health System**
898 East Main St,
Greenwood, IN 46143
Ph 317-887-1348; Fax 317-882-1631

☐ **New Vista Outpatient Recovery Center**
65 Airport Parkway, Suite 104,
Greenwood, IN 46143
Ph 317-883-5330; Fax 317-888-2120

☐ **New Vista North**
4010 W. 86th Street, Suite D,
Indianapolis, IN 46268
Ph 317-647-0102; Fax 317-868-7447

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:
Maiden/Prior Names:
Current Address:

Birth Date:
Current Phone #:
Last 4 of SS#:

To be released to or requested from:

☐ Self (release to) (address same as above)

☐

Agency/Organization | Name/Attention to | Telephone Number | Fax Number

Street Address | City | State | Zip Code

Via (when Released to): ☐ Mail ☐ Fax ☐ Pick-up ☐ Email:
☐ Verbal Exchange of Information

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other:

Dates of Service Requested:

☐ **I authorize the release of the following information <u>including</u> all records that include any substance use disorder and/or substance use disorder treatment records, or**

☐ **I authorize the release of the following information <u>excluding</u> all records that include any substance use disorder and/or substance use disorder treatment records,**

Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ Continuity/Transition of Care Packet
☐ Psychiatric Evaluation
☐ History and Physical
☐ Assessments
☐ Discharge Summary
☐ Verbal Communication with (Name):
Relationship:
☐ Progress Notes
☐ Medication Records
☐ Physician Orders
☐ Laboratory Reports/Data
☐ HIV Test Results and AIDS Treatment Records
☐ Other (specify)

This authorization will expire on ____/____/20____. (If not indicated, authorization will expire <u>180 days</u> from signature date)

This form must be completed in full before signing:

_____ _____ _____
Patient's signature (required for all) | Parent/Legal Guardian signature (if applicable) | Relationship to Patient

_____ _____ _____
Witness signature/Credentials | Date Signed | Time Signed

This authorization is intended to allow VALLE VISTA HEALTH SYSTEM to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with the copying of my information in the processing of this request.

_____ _____
Revocation Signature | Date/Time