VALLEY MEDICAL GROUP
Prevention & Medical Care To Help You Live Better, Longer.

AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION

In order to obtain copies of VMG Protected Health Information this authorization must be uploaded to **https://app.chartrequest.com/vmg**

I authorize Valley Medical Group, P.C. ("VMG") to disclose or obtain my protected health information as directed below.

I understand that this disclosure of protected health information may include sensitive information such as alcohol and or drug abuse, child abuse/neglect, sexual assault/abuse, domestic abuse, sexually transmitted diseases, termination of pregnancy, sexual preference, history of behavioral health, mental health counseling or family problems. **Any information not to be released is specified below.** I understand that the information, used, disclosed, released or obtained as a result of this authorization may be further used, disclosed or released by any recipient of this information and therefore is no longer protected by relevant privacy laws. I acknowledge that I have signed this authorization voluntarily. VMG may not condition my treatment on whether I sign this authorization and must provide me with a signed copy of this authorization.

PLEASE PRINT ALL INFORMATION

☐ STEP 1 INFORMATION ABOUT PATIENT

Name	Date of Birth	Phone
Street	City	State / Zip

☐ STEP 2 COMPLETE THIS SECTION FOR REQUESTS TO ANOTHER PROVIDER FOR RECORDS

I hereby authorize _____ to release copies of my records to VMG and mail to:

Greenfield Health Center
ATTN: HEALTH INFORMATION
329 Conway Street
Greenfield, MA 01301

☐ COMPLETE THIS SECTION FOR REQUESTS TO RELEASE PATIENT RECORDS TO A THIRD PARTY

To: _____ MD/NP/PA

Street

City State Zip

☐ STEP 3 TYPES OF RECORDS TO BE RELEASED (CHECK ALL INFORMATION TO BE RELEASED)

- ☐ Copies of medical records, including all office visits and diagnostic test reports, from _____ to _____
- ☐ Immunization records
- ☐ Specified form to be completed by
  - ☐ Disability ☐ Physical ☐ Insurance ☐ Workers' Comp

REASON FOR REQUEST

- ☐ New Physician
- ☐ Moving from area
- ☐ Second Opinion
- ☐ Litigation
- ☐ Camp Form
- ☐ Change of insurance coverage
- ☐ Work Permit
- ☐ Effective date of transfer _____
- ☐ School Form
- ☐ Other (explain)_____

☐ STEP 4 YOUR SIGNATURE

The undersigned hereby authorizes VMG to disclose or obtain protected health information concerning the above-mentioned patient. I understand that I may revoke this authorization at any time. To revoke this authorization, please complete our Authorization Revocation form. Any revocation by you will not affect any uses or disclosures permitted by your authorization while it was in effect.

_____ _____ _____
Patient's signature (Parent, Legal Guardian, or Legal Representative) | Relationship to patient | Date

This authorization expires one year from date of execution

☐ STEP 5 RELEASE OF PRIVILEGED RECORDS

I understand that in addition to the above signature in Step 4, if I want any of the following records released I must initial, sign and date on the lines below.

_____ HIV and/or AIDS testing
_____ Alcohol and/or Drug Abuse
_____ Domestic Violence/Abuse
_____ Sexual Assault/Abuse
_____ Genetic Testing
_____ Mental Health Counseling/Psychiatric Treatment
_____ Child Abuse/Neglect
_____ Sexually Transmitted Diseases

_____ _____ _____
Patient's signature (Parent, Legal Guardian, or Legal Representative) | Relationship to patient | Date