Valleywise Health

Valleywise Health
2601 E. ROOSEVELT • PHOENIX, ARIZONA 85008

VALLEYWISE HEALTH INTERNAL USE ONLY
(Check the purpose for this authorization)
- ☐ 3.1. Verbal communication throughout encounter only
- ☐ Release of sensitive information during an encounter
- ☐ Release to be processed by HIM
- ☐ No additional action needed, scan to patient chart

Patient Identifier

Place Patient Label Here

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

DT7787

NOTE: There may be a fee associated with your request for records; for more information, visit our website at www.valleywisehealth.org
Phone: (602) 344-5266 **Fax**: (602) 655-9017 **E-Mail**: ROI@valleywisehealth.org

1.0. Patient Information: (Please Print)

Patient's Name: _____

Date of Birth: _____ Phone Number: _____

Address: _____
City State Zip Code

2.0. I Authorize Valleywise Health to Disclose Protected Health Information to:

Name of Designated Recipient or Facility: RECORDS DEPOSITION SERVICE, INC.

Address: PO BOX 5054 SOUTHFIELD MI 48086-5054
City State Zip Code

Phone Number: 248.357.3330 Fax Number: 248.357.3337 E-mail Address: INFO@RECDEP.COM

2.1. Information to be Disclosed:

☐ Pertinent Information: **Specify Date/Year:** _____
(All Physician Dictations/Notes, Lab Results, Diagnostic Imaging Results and Special Test Results; if applicable)

☐ Entire Chart: **Specify Date/Year:** _____

☐ Specific Information: **Specify Date/Year:** _____

- ☐ X-ray / Diagnostic Reports
- ☐ X-ray / Diagnostic Images on CD/DVD
- ☐ Itemized Billing Statements
- ☐ Other (Specify): _____

2.2. I specifically Request Valleywise Health to EXCLUDE from Disclosure Protected Health Information Related to (Initial all that apply):

_____ AIDS/HIV and/or Other Communicable Diseases
_____ Alcohol and/or Drug Abuse Treatment
_____ Behavioral Health Care/Psychiatric Care/Mental Health Information
_____ Genetic/Infertility Testing Information

3.0. Release/Delivery Method

- ☐ MyChart
- ☐ CD
- ☐ USB Drive
- ☐ Paper
- ☐ Mail Records
- ☐ Pick-Up Records
- ☒ E-Mail**
- ☐ Fax to Care Provider

****E-Mail is not a secure means of communication. We will encrypt e-mail communications containing your records unless you tell us you prefer Valleywise Health to use unencrypted e-mail. If you prefer, we not encrypt our communications to you, your initials permit Valleywise Health to e-mail your requested information unencrypted. However, if a file size limitation exists an alternate format to receive your records will be required. **Initial Here:** _____

3.1. Verbal Communication: I authorize Valleywise Health to verbally discuss my protected health information and the specific protected health information in section 2.2. to the individuals listed in 2.0. above during my treatment. Verbal communication is specifically authorized for current treatment and/or coordination of care by Valleywise Health. **Initial Here:** _____

4.0. Specific Description of the Purpose/Reason of the Disclosure:

- ☐ Continued Patient Care
- ☐ Personal Use
- ☐ Workers' Compensation
- ☒ Legal
- ☐ Insurance Coverage or Payment for Care
- ☐ Other: (Specify)_____

5.0. Patient Rights:

- I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. The provider will not deny me treatment if I do not wish to sign this form. I understand that I may refuse to sign this authorization form.
- I may revoke this authorization at any time, with some exceptions, if I do so in writing and submit the request to Medical Records. The revocation will take effect when Valleywise Health receives it, except to the extent that Valleywise Health or others have already relied on it. For more details on when I can and cannot revoke this authorization, I can read the Valleywise Health' Notice of Privacy Practices.
- Unless otherwise specified or revoked in writing, this Authorization will expire on/when_____ if a specific date/event is not provided above, this authorization will expire one (1) year after the date of signature.
- I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
- I am entitled to receive a copy of this Authorization.
- I understand the matters discussed on this form. I authorize Valleywise Health, its employees, agents, officers, directors and medical staff members from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Patient Signature/ Legal Representative | Print Name | Relationship to Patient /Authority to Act for Patient | Date