MEDICAL INFORMATION RELEASE FORM
RECORDS RELEASED TO VALLEY MEDICAL CENTER

Patient Name:_____

Patient Address:_____

Patient Telephone:_____ Patient Date of Birth:_____

1. I hereby authorize the use or disclosure of the above named individual's health information as describe below.

2. The following individual / organization is authorized to make the disclosure;
   Name: _____
   Address: _____

3. Description of what is to be disclosed:
   _____Entire Medical Record
   _____Partial Medical Record **(Dates Required)**_____

_____Lab Results	_____Clinical Notes	_____Referral Record
_____Prescription Record	_____X-Ray Reports	_____Immunization Record
_____Auto Injury	_____Worker's Comp	_____Physical Examination

4. This information may be disclosed to and used by the following individual or organization.
   Name: _____Priscilla J. Benner M.D. T/A Valley Medical Center_____
   Address: _____P.O. Box 216, Pennsburg, PA 18073_____

5. Purpose of disclosure: _____My personal records (Charge not to exceed state maximum)
   _____Change in Doctors Office/Primary Care
   _____Sharing with healthcare providers as needed
   _____At the request of my attorney – Attorney's Name / Address
   Other:_____

6. I understand that:
   - This authorization is strictly voluntary and I may refuse to sign it if I so choose.
   - My refusal to sign this authorization will not affect my ability to obtain treatment, except when health services are solely for the purpose of reporting to a third party.
   - I may revoke this authorization at any time in writing, but if I do, it will not apply to any disclosure already made in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with rights to contest a claim under my policy.
   - Once the information listed above has been disclosed, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations.
   - I may see and obtain a copy of the information described on this form, for a reasonable copy fee.

7. This authorization will expire six months from the date of signature unless you request an earlier date or event.
   Expiration Date:_____ Event:_____

8. Specially protected information (please check all that apply).
   - ❑ I understand that the information to be disclosed may include information relating to AIDS or HIV.
   - ❑ I understand that the information to be disclosed may include information relating to psychiatric or other mental health treatment.
   - ❑ I understand that the information to be disclosed may include information about treatment for drug, alcohol, or substance abuse.

I have read and understand this authorization and authorize the use and/or disclosure of the protected health information as described in this authorization.

Signature of Patient/Guardian:_____ Date:_____

Photo ID required for records to be picked up. Relationship to Patient:
Witness to ID_____ _____