VALLEY MEDICAL GROUP

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

AUTHORIZATION TO DISCLOSE OR OBTAIN MEDICAL INFORMATION

☐ **Amherst Medical Center**	☐ **Greenfield Health Center**	☐ **Northampton Health Center**	☐ **Easthampton Health Center**
31 Hall Drive	329 Conway Street	70 Main Street	238 Northampton Street
Amherst, MA 01002	Greenfield, MA 01301	Florence, MA 01062	Easthampton, MA 01027

I authorize Valley Medical Group to use, disclose or obtain my medical information as directed below.

I understand that this may include sensitive information such as alcohol and drug usage, child abuse/neglect, sexual assault/abuse, sexually transmitted diseases, termination of pregnancy, sexual preference, history of behavioral health, counseling/family problems. **Any information not to be released is specified below.** I understand that information used, disclosed, or obtained as a result of this authorization may be further used or disclosed by someone who obtains this information and therefore may no longer be protected by relevant privacy laws. I acknowledge that I have signed this authorization voluntarily.

HIV & BEHAVIORAL HEALTH RECORDS WILL NOT BE DISCLOSED UNLESS YOU SIGN THIS AUTHORIZATION AS WELL AS SPECIFIC AUTHORIZATIONS ON THE BACK OF THIS FORM.

PLEASE PRINT ALL INFORMATION.

PATIENT INFORMATION

Name		Maiden or former name	
Street		Date of Birth	Social Security #
City	State Zip	Phone #	

REQUESTING INFORMATION (If different from patient or recipient)

Name Organization/Realtionship

Street

City State Zip

☐ REQUESTING INFORMATION *To be sent to* VALLEY MEDICAL GROUP, 179 Northampton Street, Easthampton, MA 01027

Name Organization

Street

City State Zip

☐ REQUESTING INFORMATION *To be sent from* VALLEY MEDICAL GROUP

Name Organization

Street

City State Zip

CHECK ALL INFORMATION TO BE RELEASED.

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

**REVIEW OTHER SIDE OF THIS PAGE FOR ADDITIONAL CONFIDENTIAL INFORMATION RELEASE*

☐ I will pick up information. Call when ready.

- ☐ Test reports **only** _____ (specify type) _____ (/date of test)
- _____ (specify type) _____ (/date of test)
- ☐ Other _____ (specify type) _____ (/date of test)

Information I *DO NOT* want released.

☐ **DO NOT** release: (Specify)

REASON FOR REQUEST:

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

AUTHORIZATION EXPIRATION DATE:

This authorization expires on _____(or, if unspecified, 180 days from the date of signature).

I HAVE READ AND UNDERSTAND THE AUTHORIZATION FORM.

The undersigned hereby authorizes Valley Medical Group to send or obtain medical 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

Valley Medical Group must provide you with a copy of this signed authorization form.