AUTHORIZATION FOR RELEASE OF PROTECTED HEATH INFORMATION (PHI)

1717 Arlington Ave., Caldwell, ID 83605
Toll Free phone: 1-866-270-2311 Toll Free Fax: 1-877-865-9738

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Last Four Digits SSN (optional):**	
Provider's Name: West Valley Medical Center	**Recipient's Name:**		
Provider's Address: 1717 Arlington Ave. Caldwell, ID 83605	**Address:**		
	City:	**State:**	**Zip:**
	Billing Address: (if not same as above)	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided): ☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.,* USB drive, CD/DVD, email) NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (*e.g.,* paper copy).**

Email Address (If email checked above. Please print legibly):

This authorization will expire in ninety days form the date of signature unless otherwise indicated below (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	***Date(s):***	***Description:***	***Date(s):***	***Description:***	***Date(s):***
☐ All PHI in medical record		☐ Operative information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing information		☐ UB-04:	
☐ Clinical test		☐ Transfer forms		☐ Other:	
☐ Medication sheets		☐ ER information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _______________ (Initial Required)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**
For Children under 18 years of age: I have legal custody of this minor child ______Please initial	

ID type, ID number, and exp date

Name of person witnessing signature and/or releasing information
(please print-required)

WVMC Form 8320 Revised 9/2013