



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

AUTHORIZATION TO DISCLOSE OR OBTAIN MEDICAL INFORMATION

<input type="checkbox"/> Amherst Medical Center 31 Hall Drive Amherst, MA 01002	<input type="checkbox"/> Greenfield Health Center 329 Conway Street Greenfield, MA 01301	<input type="checkbox"/> Northampton Health Center 70 Main Street Florence, MA 01062	<input type="checkbox"/> Easthampton Health Center 238 Northampton Street Easthampton, MA 01027
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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/Relationship	
Street			
City	State	Zip	
<input checked="" type="checkbox"/> REQUESTING INFORMATION To be sent to VALLEY MEDICAL GROUP, 179 Northampton Street, Easthampton, MA 01027			
Name		Organization	
Street			
City	State	Zip	
<input checked="" type="checkbox"/> REQUESTING INFORMATION To be sent from VALLEY MEDICAL GROUP			
Name		Organization	
Street			
City	State	Zip	
CHECK ALL INFORMATION TO BE RELEASED.		<input checked="" type="checkbox"/> I will pick up information. Call when ready.	
<input type="checkbox"/> Copies of medical records, including all diagnostic test reports from _____ to _____ <input type="checkbox"/> Immunization records <input type="checkbox"/> Specified form to be completed by <input type="checkbox"/> Disability <input type="checkbox"/> Physical <input type="checkbox"/> Insurance <input type="checkbox"/> Workers' Comp <i>*REVIEW OTHER SIDE OF THIS PAGE FOR ADDITIONAL CONFIDENTIAL INFORMATION RELEASE</i>		<input type="checkbox"/> Test reports only _____ <small>specify type /date of test</small> <input type="checkbox"/> _____ <small>specify type /date of test</small> <input type="checkbox"/> Other _____ <small>specify type /date of test</small>	
Information I DO NOT want released.			
<input type="checkbox"/> DO NOT release: (Specify)			
REASON FOR REQUEST:			
<input type="checkbox"/> New Physician	<input type="checkbox"/> Camp Form	<input type="checkbox"/> Change of insurance coverage	
<input type="checkbox"/> Moving from area	<input type="checkbox"/> Work Permit	<input type="checkbox"/> Effective date of transfer _____	
<input type="checkbox"/> Second Opinion	<input type="checkbox"/> School Form	<input type="checkbox"/> Patient request	
<input type="checkbox"/> Other (explain) _____			
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.