AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

VBH ID#: _____

Date of Birth: _____

Client Name: _____ **Other Names Used:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **Email:** _____

I authorize Valley Behavioral Health to release my protected health information to:

Name: _____ Phone #: _____

Agency: _____ Fax #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Method of Delivery: _____

This authorization is for: *(choose only one)* ☐ Upload to chart for future release ☐ Send records now

☐ 2-way *verbal* communication only

Purpose of request: ☐ Coordination of Care ☐ Legal ☐ Personal ☐ Other (must specify) _____

Information to be Disclosed:

Mental Health: ☐ Assessment ☐ Care Plan ☐ Individual Therapy Notes ☐ Med Notes

☐ Billing Records ☐ Other (must specify) _____

Substance Use Disorder: ☐ Assessment ☐ Care Plan ☐ Individual Therapy Notes ☐ Med Notes

☐ Billing Records ☐ Other (must specify) _____

Dates of Service to be Released: ☐ All Dates ☐ Specific Date Range _____

Expiration of Authorization:** (must enter specific date) _____

**If no expiration date is entered, this authorization will expire 1 year from date signed.

I understand:

- I can request a copy of my record. My provider(s) will review my request and the request can be denied if the records are found to be detrimental to myself, my treatment, or others. Requests can take up to 30 days to complete and charges may apply.
- Medical and mental health records are protected by Federal and State confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations.
- My substance use disorder records are protected under federal law, 42 CFR Part 2, and the Health Insurance Portability & Accountability Act of 1996, 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
- This form is voluntary and not required to receive services with Valley Behavioral Health unless the purpose of the disclosure is for purposes of treatment, payment, or healthcare operations, if permitted by state law.
- This authorization may be revoked at any time. If this authorization is for court-ordered treatment, it cannot be revoked. Revocation will not include any information already shared in reliance upon this authorization.
- Disclosure of this information has the potential for an unauthorized re-disclosure and may not be protected by Federal confidentiality rules. Valley Behavioral Health does not re-disclose PHI received from third-party providers, entities, and/or agencies except where required by law.

I further consent to, and agree, that any electronic signatures by me are valid and enforceable as if I signed in person.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Printed Name of Representative Relationship to Client

_____ _____

Staff Signature Date

VBH Medical Records Contact Information: P: 801-273-6425, F: 385-388-8670, medicalrecords@valleycares.com V 3.2023