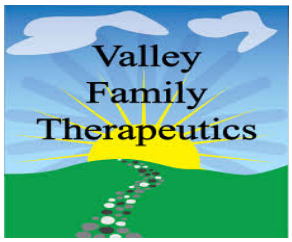

HIPPA RELEASE OF INFORMATION
AUTHORIZATION FORM

I authorize Valley Family Therapeutics to use and disclose the protected health information to the extent described below to _____(individual seeking information).

This release covers the period of healthcare from:

☐ I authorize the release of all past, present, and future periods of care to above recipient.

☐ I authorize only the release of information from the period of healthcare from_____ to _____.

I authorize the release of:

☐ My complete health record (including information relating to diagnosis, treatment, payment, and personal information which identifies me).

☐ My complete health record (including information relating to diagnosis, treatment, payment, and personal information which identifies me) **EXCEPT** _____
_____

The signature on this form indicates my understanding that:

- This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
- I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- Information used or disclosed to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
- I have a right to a copy of this authorization upon my request.
- This authorization is voluntary and I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits, enrollment, or payment for coverage of services.

Printed Name of Patient_____DOB:_____

Signature of Patient or Patient Representative_____
Relationship to Patient_____

Date_____