**Valley-Wide Health Systems, Inc.**
**Authorization for Release of Protected Health Information**

**I.** **Please describe the Protected Health Information to be used or disclosed that identifies the information in a specific and meaningful fashion;**
_____

_____

_____

**II.** **Name of person making the request, or relationship to, authorized to make request.**
**Name: _____Date of Birth:_____**

**___ Individual ___ Personal Representative ____ Parent ____Guardian**
**___ Other, _____**

**III.** **To whom may the covered entity disclose or make the requested use or disclosure.**
**Name: _____**
**Address: _____**

**Name: _____**
**Address: _____**

**IV.** **Please provide a date that you would like this authorization to expire. If no date is listed, this authorization will remain in affect for a period of one (1) year from the date of signature.**
**Date of Expiration: _____**

**V.** **The individual has the right to revoke this authorization at any time. However, ValleyWide Health Systems, Inc. cannot be held responsible for information already disclosed based on this authorization. In order to revoke this authorization, the individual must complete a revocation form identifying this authorization by initiation date.**

**VI.** **Information used or disclosed as a result of this authorization, may be subject to redisclosure by persons receiving this information and no longer protected by this rule.**

**VII.** **Signature of individual: _____**

**Date: _____**

**VIII.** **Signature of Personal Representative: _____**

**Date: _____**