ASPEN VALLEY HOSPITAL

Medical Records Phone 970-544-1290
Medical Records Fax 970-544-1587

# AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, born on _____,
Patient's Full Name Date of Birth

and residing at _____,
Address, City, State, Zip, Telephone #

authorize _____
to release information from my medical record. This authorization includes release of information concerning treatment of psychiatric or psychological conditions, drug and/or alcohol conditions, and HIV or AIDS related conditions or testing.
Information I authorize to be released:

[ ] Specific Date of Service:_____
[ ] Entire Medical Record [ ] Discharge Summary [ ] ER Record
[ ] History and Physical [ ] Operative Report [ ] Pathology Report
[ ] Laboratory results [ ] Radiology results (report)
[ ] Radiology results (images)
[ ] Itemized Bill ***(not included with Entire Medical Record unless specified)***
Other:_____

The information is to be released to: I would prefer records be sent via: [ ] Postal Mail [ ] E-mail

| | |
|---|---|
| ***Name of Person/Organization*** | ***Street Address*** |
| ***City, State, Zip*** | ***Telephone #*** |
| ***E-Mail Address*** | ***Fax # (Physicians and Facilities only. Patients for time sensitive results only)*** |

I request this information to be released for the purpose of:
[ ] Continued medical care [ ] Personal interest [ ] Billing/and or Claims [ ] External Review
[ ] Other: _____

I understand I may revoke this authorization at any time except to the extent action has been taken prior to revocation. Revocation must be made in writing. This authorization will expire on _____. I affirm that I have read and understand the above statements as they apply to me. I understand that treatment, payment, enrollment in any health plan, or eligibility for benefits are not conditioned on signing this authorization. I hereby authorize the disclosure of the medical records to the purpose and extent stated above. I understand that once these records are released, the information is not protected by the releasing entity.

_____ _____ _____
Patient's Signature Date Signed Time Signed

_____
Parent, Guardian, Authorized Representative

_____
Relationship to Patient

| ****Non-Medical Records Staff to Complete** | ****Medical Records Staff to Complete** |
|---|---|
| ID Checked/Verified **Y/N** | ID Checked/Verified **Y/N** |
| Records Released/Given to patient **Y/N** If yes by:_____ | Records Released/Given to patient **Y/N** If yes by:_____ |
| Date Released: ____/____/____ | Date Released: ____/____/____ |
| Released Via: [ ] Mail [ ] Fax [ ] In Person [ ] Email | Released Via: [ ] Mail [ ] Fax [ ] In Person [ ] Email |
| | Entered in Correspondence **Y/N** If yes by:_____ |