

REQUEST FOR MEDICAL RECORDS AND AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION FROM OTHER FACILITY

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:

- | | | |
|--------------------------------------------------------------------------|--------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Record |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Pathology Report |
| <input type="checkbox"/> Diagnostic Testing Results (lab, x-ray, images) | | |

Other: _____

The information is to be released to: Aspen Valley Primary Care Clinic **FAX TO 970-927-3915**
 1460 East Valley Road Suite 103
 Basalt, CO 81621
 FAX: 970-927-3915

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 to Aspen Valley Hospital. 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

AVH Staff to Complete:
 ID Checked
 Released by _____
 Date ____/____/____
 Via: Mail Fax In Person Email
 Entered in Correspondence by _____