AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Released From:

Select all that apply: *

- Gunnison Valley Hospital
- General Surgery
- Family Medicine Clinic
- Campus Health Clinic

Patient Name *

Patient's Date of Birth *

Month Day Year

Mailing Address *

City *

State *

Zip *

Phone *

Released To:

Released to: *

- Patient
- Other facility

Other Person or Other Facility Name

Delivery *

- Pickup (patient or other person only)
- Email
- Fax
- Mail

Mailing Address *

City *

State *

Zip *

Phone *

Email

example@example.com

Fax

Please enter a valid fax number.

Information to be Copied and Released

Check all that apply *

- Emergency Room Report
- History & Physical
- Operative Reports
- Nurses Notes
- Lab/Pathology Results
- Respiratory
- Billing Records
- Non-GVH Medical Records
- Discharge Summary
- Consultation Reports
- Physician Progress Notes
- Medication Records
- Radiology Report
- Rehab Services
- Patient Care Photos
- Non-GVH Family Clinic Medical Records

Date of Service *

Month Day Year

List additional dates of service:

I consent to release of information relating to psychiatric or psychological testing or treatment, alcohol, and/or drug abuse diagnosis, prognosis and treatment, and/or HIV (AIDS) testing and/or results, genetic testing/results, sickle cell anemia testing/results.

*****NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released.**

Do you consent to the statement above? *

I do consent

I do NOT consent

The purpose for this release: *

Continuity of Medical Care

Damage/Claim Information

Personal Use

Legal

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and that there may be a cost to copy these records.

I understand that **this consent expires one year from the date of my signature** unless otherwise specified below*. I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax, or scan of this form is to be considered as valid as the original. Please retain a copy of your records for your personal use.

*other specification for consent expiation:

Signature of Patient/Representative:

Representative's relationship to patient:

Date

Month Day Year

Time *

Hour Minutes

PLEASE ALLOW 10 DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED