FAMILY MEDICINE CLINIC AND CAMPUS HEALTH CENTER

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

970-641-7252 | 970-641-9017 (FAX)

Authorization to Release and/or Obtain Patient Information

Released from: ☐ GVH Family Medicine Clinic
☐ Gunnison Valley Hospital
☐ Campus Health Center

Released to: ☐ Patient
☐ Other Person/ Relationship:___________________
☐ Other Facility

Patient Name ______________________________

Mailing Address ______________________________

City State Zip ______________________________

Phone Fax ______________________________

Other Person or Other Facility Name ______________________________

Mailing Address ______________________________

City State Zip ______________________________

Phone Fax ______________________________

Patient's Date of Birth: __________________________

Email Address:

Patient: ☐ Pick Up ☐ Fax ☐ Mail
Other Person: ☐ Pick Up ☐ Fax ☐ Mail
Facility: ☐ Fax ☐ Mail

INFORMATION TO BE COPIED AND RELEASED (CHECK ALL THAT APPLY):

Date(s) of service: ____

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

I DO ☐ or **I DO NOT** ☐ 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. *****

THE PURPOSE FOR THIS RELEASE:
☐ Continuity of Medical Care ☐ Damage/Claim Information ☐ Personal Use ☐ Legal
☐ Other: ____

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 as follows: ______________________. 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.**

______________________ ____________ ______________________ ____________
Signature of Patient/Representative **Date/Time** **Signature of Witness** **Date/Time**

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Relationship to Patient

Name of GVH staff person who released medical records: ______________________________ **Date:**__________

PLEASE ALLOW 10 DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED

Updated 12/28/2016