HOSPITAL & CLINICS AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

GUNNISON VALLEY HEALTH

Gunnison Valley Health Medical Records
711 N. Taylor St.
Gunnison, CO 81230

Phone: 970-641-7257 or 970-641-7252
Fax: 970-641-7273
Email: mr@gvh-colorado.org

Patient Information

Patient Name: _____ **Date of Birth:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email: _____ **Phone:** _____

Records Request

I request my records FROM:

☐ Gunnison Valley Hospital	☐ Oncology	☐ Dermatology
☐ Family Medicine Clinic	☐ General Surgery	☐ Urology
☐ Campus Health Clinic	☐ Ophthalmology	☐ ENT
☐ Gunnison Valley Orthopedics	☐ Women's Health Clinic	
☐ Other (Specify):		

I request my records be sent TO:

☐ **Self (Patient Only)** **Select method of release:** ☐ **Email** ☐ **Fax** ☐ **Mail** ☐ **Pick Up**

☐ **Other: Name of Facility, Other Person:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____ **Email** _____

I request my records to be released to another facility by the following method: ☐ **Email** ☐ **Fax** ☐ **Mail** ☐ **Pick Up**

Dates of Service: **From:** _____ **To:** _____

Select What Type of Records:

☐ Lab Results / Pathology	☐ Clinic Office Visit Notes	☐ **Drug / Alcohol Treatment**
☐ Radiology Reports (MRI, CT, X Ray, US)	☐ History & Physical	☐ **Family Planning / Reproductive Health**
☐ Radiology Images on a CD	☐ Discharge Summary	☐ **Genetic Testing**
☐ Radiology Images via email link (Ambra)	☐ Medication Report	☐ **HIV / AIDS Information**
☐ Emergency Room Report	☐ Immunization Record	☐ **Sickle Cell Information**
☐ Urgent Care/Mountain Clinic Report	☐ Rehab Notes (PT/OT/ST)	☐ **STD / Communicable Diseases**
☐ Operative / Procedure Report	☐ Itemized Bill/Claim Form (UB/1500)	☐ **Other (Specify):** _____
☐ Respiratory/Cardiology		

☐ **I DO or** ☐ **I DO NOT** consent to release information relating to psychiatric or psychological testing or treatment, alcohol, and or drug abuse diagnosis, prognosis and treatment, and /or HIV/ AIDS 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. *****

Purpose for Release

☐ Treatment / Further Medical Care ☐ Personal ☐ Insurance ☐ Legal ☐ Other:

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Disclosers

Acknowledgments & Authorization Signature

By signing this Authorization, I acknowledge that I have read this Authorization form and understand that:

- I may refuse to authorize the disclosure of some or all of the above health information but that my refusal may result in improper diagnosis or treatment, denial of coverage or claims for health insurance benefits or other insurance, or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying GVH in the manner described in GVH's Notice of Privacy Practices, except to the extent that GVH or any other person has already acted in reliance on it. I understand that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- There is the potential that information disclosed pursuant to this Authorization may be redisclosed by the recipient(s) of the information and that as a result, the information may no longer be protected.
- Incomplete forms cannot be processed.
- The disclosing entity may charge a fee for copying the requested records.
- A copy, fax or scan of this Authorization will be considered as valid as the original.
- I have the right to receive a copy of this signed authorization.

PLEASE ALLOW 10 DAYS TO FULFILL RECORDS REQUESTS

Signature of Patient/Guardian/Authorized Representative* _____

Relationship _____ **Date** _____

Authorized Representative's Legal Authority:

- ☐ Medical Durable Power of Attorney Agent
- ☐ Guardian
- ☐ Conservator
- ☐ Healthcare Proxy Decision Maker
- ☐ Parent of Minor
- ☐ Surrogate Decision Maker for Healthcare Benefits
- ☐ Benefactor of Estate

*Signature by an authorized representative certifies that such person has the legal authority to authorize the disclosure on behalf of the patient.

Name of Staff Person Disclosing Records: _____ Date: _____ ☐ Mailed ☐ Faxed ☐ Email ☐ Pick Up