HOSPITAL AND CLINIC AUTHORIZATION TO OBTAIN PATIENT 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:** _____

Authorization

I hereby authorize GVH to obtain my Health Information FROM:

Facility Name: _____

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

Email: _____ **Phone:** _____

Fax: _____

Release TO:

Name of Clinic Health Information is to be released to:

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

Records Released

Requested Date(s) of Service:

☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ All Records ☐ Specific Date: _____

Records to be released:

☐ Emergency Report	☐ History and Physical	☐ Labs	☐ Operative Notes
☐ Discharge Summary	☐ Progress Notes	☐ Radiology Reports	
☐ Respiratory	☐ Medication Records	☐ Cardiac	
☐ Other (Specify): _____			

Purpose for Release

☐ Treatment / Further Medical Care ☐ Damage/Claim ☐ Legal ☐ Other: _____

☐ **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. *****

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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, and that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete form cannot be processed.

I understand that this consent expires one year from the date of my signature unless 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 the expiration, and 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.

Signature of Patient/Guardian/Authorized Representative* _____

Relationship _____ **Date** _____

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

Name of GVH staff requesting records _____

Date request was sent to facility _____