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

AUTHORIZATION TO DISCLOSE/OBTAIN HEALTH INFORMATION

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

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

To Disclose/Release to AND/OR

Name of Entity, Facility, Other Person, Self: _____

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

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

I would like copies of the items checked below in the following format: (Paper format - U.S. Mail is default if not marked.)

- ☐ Paper Format - U.S. Mail
- ☐ Fax
- ☐ AMBRA (Radiology Image)
- ☐ Paper Format - Pick Up
- ☐ Secure Email to: _____

Date(s) of Service: _____

Information to be Copied and Released: (Check all that apply.)

- ☐ Emergency Room Report
- ☐ Nurses Notes
- ☐ Respiratory/EKG
- ☐ Discharge Summary
- ☐ Medication Records
- ☐ Rehab Services
- ☐ History and Physical
- ☐ Physicians Orders
- ☐ Billing Records/UB04
- ☐ Consultation Reports
- ☐ Lab/Pathology Results
- ☐ Patient Care Photos
- ☐ Operative Reports
- ☐ Radiology Report
- ☐ Non-GVH Medical Records
- ☐ Physician Progress Notes
- ☐ Radiology Images
- ☐ Other (Specify): _____

I intend this authorization to include disclosure of the following types of particularly sensitive health information: (if a box is not checked, such records will not be disclosed.)

- ☐ Mental Health Information and Records
- ☐ Psychotherapy Notes
- ☐ Genetic Information and Records
- ☐ Sickle Cell Anemia Tests/Results
- ☐ Sexually Transmitted Infection (STI), including HIV/AIDS, Information and Records
- ☐ Substance Use Disorder (SUD) Information and Records, including SUD Information and Records Subject to Protection under 42 C.F.R. Part 2

Purpose of Disclosure:

☐ Continuity of Care ☐ Damage/Claim Information ☐ Personal Use ☐ Legal ☐ Other: _____

This authorization will expire one year from the date of my signature below unless I enter an earlier expiration date or event here: _____

ACKNOWLEDGMENTS AND 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 BUSINESS 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.

For office use only when GVH is disclosing of records.

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