AUTHORIZATION TO DISCUSS MEDICAL 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

Information to Discuss

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below. Description of the specific information to be discussed:

☐ Appointment Date/Times ☐ Diagnosis ☐ Imaging Results ☐ Medications ☐ Lab Tests/Results ☐ Summary of Medical Record

☐ Care Plan ☐ Other (Specify): _____

Please choose from the following:

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

Indicate Information with special protections:

☐ Mental Health ☐ HIV Information ☐ Alcohol/Drug Information

Patient Legal Name: _____ Date of Birth: _____

Information to be given to:

Name: _____ Relationship: _____

Phone Number(s): _____

Name: _____ Relationship: _____

Phone Number(s): _____

Authorization

This authorization shall remain in effect from the date signed below until (please check one):

☐ Specific Date: _____ ☐ NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office, attention Practice Manager.
- This authorization is giving the above clinic(s) the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research related treatment).

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.