AUTHORIZATION TO DISCLOSE/OBTAIN 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

Select the GVH facility/group from which you are requesting records:

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

Patient Name: _____ **Formerly Known As:** _____ **Date of Birth:** _____

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

Purpose of Request: ☐ Continuation of Care ☐ Personal ☐ Legal ☐ Insurance ☐ Other: _____

To Disclose/Release to AND/OR Obtain From:

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

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

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

Date of service range (month/year): From: _____ **to:** _____

Select method of release:

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

☐ Billing/UB04	☐ History & Physical	☐ Physicians Orders
☐ Clinic/Progress Notes	☐ **HIV/AIDS Information***	☐ Radiology Report
☐ Discharge Summary	☐ Immunization Record	☐ Radiology CD Images
☐ **Drug/Alcohol Treatment***	☐ Lab/Pathology Results	☐ Respiratory/Cardiology Reports
☐ Emergency Room Report	☐ Non-GVH Medical Records	☐ Rehab Services
☐ Facesheet	☐ Nurses Notes	☐ **Sickle Cell Information***
☐ **Family Planning/Reproductive Health***	☐ Medication Records	☐ **STD/Communicable Diseases***
☐ **Genetic Information***	☐ Patient Care Photos	☐ Other (Specify): _____

***I hereby consent to disclose the above bolded specialized information.** _____

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
- ☐ Healthcare Proxy Decision Maker
- ☐ Benefactor of Estate
- ☐ Guardian
- ☐ Parent of Minor
- ☐ Conservator
- ☐ Surrogate Decision Maker for Healthcare Benefits

*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