ASPEN VALLEY HOSPITAL

ASPEN VALLEY HOSPITAL
CENTER FOR MEDICAL CARE

Medical Records Phone 970-544-1290
Medical Records Fax 970-544-1587

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, _____, born on _____,
Patient's Full Name Date of Birth

and residing at _____,
Address, City, State, Zip, Telephone #

authorize _____
to release information from my medical record. This authorization includes release of information concerning treatment of psychiatric or psychological conditions, drug and/or alcohol conditions, and HIV or AIDS related conditions or testing. Information I authorize to be released:

[ ] **Specific Date of Service**:_____

[ ] Entire Medical Record	[ ] Discharge Summary	[ ] ER Record
[ ] History and Physical	[ ] Operative Report	[ ] Pathology Report
[ ] Laboratory results	[ ] Radiology results (report)	[ ] EKGs/Cardio/Echo
[ ] Radiology results (images)	[ ] Immunizations	[ ] Physical Therapy Notes

[ ] Itemized Bill ***(not included with Entire Medical Record unless specified)***

Other:_____

Delivery of Information:

Preferred Method: Date Information needed (mm/dd/yyyy) _____

☐ Written copy ☐ Verbal Only (*we cannot interpret results-only read information as written/provided*)

*Written information will be mailed unless an alternate method is checked

☐ Pick-up in person at AVH

☐ Encrypted Email

☐ **By checking this box**- I authorize protected health information to be sent unencrypted to the email address noted

☐ CD (Images only)

☐ Other, specify: _____

Name of Person/Organization	***Street Address***
City, State, Zip	***Telephone #***
E-Mail Address	***Fax # (Physicians and Facilities only. Patients for time sensitive results only)***

I request this information to be released for the purpose of:
[ ] Continuing Care [ ] Personal interest [ ] Insurance [ ] Billing/and or Claims [ ] External Review [ ] Disability
[ ] Worker's Compensation [ ] Legal [ ] Other: _____

**This Authorization will expire 1 year from date of signature unless another date is specified: _____

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☐ **By checking this box-**I allow the ongoing exchange of information (written and verbal) between the above parties until this authorization expires or is revoked.

☐ **By checking this box-**I also authorize the release of records for future visit or stays after the date of my signature until this authorization expires or is revoked.

- This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department—except to the extent that the Provider(s) have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy law (42 CFR Part 2) (HIPAA).
- I understand that Aspen Valley Hospital will not condition treatment on whether I sign this authorization.
- I understand that treatment, payment, enrollment in any health plan, or eligibility for benefits are not conditioned on signing this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have the right to inspect and receive a copy of the material(s) to be disclosed.

I affirm that I have read and understand the above statements as they apply to me. I hereby authorize the disclosure of the medical records to the purpose and extent stated above.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's individual consent.

_____ _____ _____
Patient's Signature Date Signed Time Signed

_____
Parent, Guardian, Authorized Representative

_____
Relationship to Patient
(Legal documentation of the right to access by the signing individual may be required)

**Non-Medical Records Staff to Complete	**Medical Records Staff to Complete
ID Checked/Verified **Y/N**	ID Checked/Verified **Y/N**
Records Released/Given to patient **Y/N** If yes by:_____	Records Released/Given to requestor **Y/N** If yes by:_____
Date Released: ____/____/____	Date Released: ____/____/____
Released Via: [ ] Mail [ ] Fax [ ] In Person [ ] Email	Released Via: [ ] Mail [ ] Fax [ ] In Person [ ] Email
	Entered in Correspondence **Y/N** If yes by:_____