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 Aspen Valley Hospital 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 from date(s) of service: ______________________.

[ ]Entire medical record
[ ]History and Physical
[ ]Laboratory results
[ ]Radiology results (report)
[ ]Radiology results (images)
[ ]Discharge Summary
[ ]Operative Report
[ ]Itemized Bill
[ ]Other: ______________________________
[ ]ER Record
[ ]Pathology Report

The information is to be released to: I would prefer records be sent: [ ]Postal mail [ ]E-mail

Name of Person/Organization	***Street Address***
City, State, Zip	***Telephone #***
E-Mail Address	***Fax # (For faxing to Physicians and Facilities Only)***

I request this information to be released for the purpose of:
[ ]Continued medical care [ ]Personal interest [ ]Billing and/or Claims [ ]External review
[ ]Other: ______________________________

I understand I may revoke this authorization at any time except to the extent action has been taken prior to revocation. Revocation must be made in writing to Aspen Valley Hospital. This authorization will expire on ____________. I affirm that I have read and understand the above statements as they apply to me. I understand that treatment, payment, enrollment in any health plan, or eligibility for benefits are not conditioned on signing this authorization. I hereby authorize the disclosure of the medical records to the purpose and extent stated above. I understand once these records are released, the information is not protected by Aspen Valley Hospital.

____
Patient's Signature

____
Date Signed

____
Parent, Guardian, Authorized Representative

____
Relationship to Patient

AVH Staff to Complete:
[ ] ID Checked
Released by ______________
Date____/____/____
Via [ ]Mail [ ]Fax [ ]In Person [ ]E-mail
[ ] Entered in Correspondence MT by _____

Revised 03/09/10