Please send the completed form one of the following ways: Email to myportal@vvh.org, fax to 970-384-8179, or mail to Valley View Hospital Attn: Medical Records 1906 Blake Ave. Glenwood Springs, CO 81601

1. Patient Name: _____ **Date of Birth:** _____

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

Email Address: _____ **Phone #:** _____

2. I request my records from:

☐ Valley View Hospital (ACU, CCU, ER, Urgent Care, Lab & Radiology)

☐ Calaway-Young Cancer Center
☐ Eagle Valley Family Practice
☐ Foot & Ankle Center
☐ Gastroenterology Center
☐ Heart & Vascular Center
☐ Internal Medicine
☐ Lung Center
☐ Neurology Center
☐ Rehabilitation Services
☐ Roaring Fork Family Practice
☐ Rocky Mountain Urology
☐ Silt Family Practice
☐ Valley Ortho
☐ Women's Health at VVH
☐ Wound Care Center
☐ Roaring Fork Surgical
☐ Spine Center
☐ Mount Sopris Plastic Surgery/ Breast Center at VVH

☐ Other: _____

3. I request my records be sent to:

☐ Self (patient only)

☐ Other: Name of Facility or Person _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone # _____ Fax # _____ Email Address: _____

4. I request my records to be released by the following method: ☐ Email ☐ Fax ☐ Mail

Dates of Service: From _____ To _____

5. Please select below what types of records are to be released:

☐ Anesthesia Records
☐ Billing Records
☐ Consultations
☐ Diagnostic Test Reports
☐ Discharge Summary
☐ Emergency Room/Urgent Care
☐ History & Physical Exam
☐ Immunization Record
☐ Lab Results/Pathology
☐ Medication Records
☐ Office Visit Notes
☐ Operative/Procedure Reports
☐ Radiology Reports (MRI, CT, X-Ray, US)
☐ Radiology Images
☐ Rehab Notes (PT/OT/ST)

☐ Other: _____

6. Purpose for Release: ☐ Further Medical Care ☐ Personal ☐ Insurance ☐ Legal ☐ Other: _____

7. I understand that your facility may receive compensation for medical record copying in accordance with State law.

8. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain.

9. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

10. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #8 above.

11. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

12. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. **This authorization expires within 365 days, or the duration of (event).**

_____ _____ _____ _____

Signature of Patient/Representative **Date/Time** **Witness Signature** **Date/Time**

(If signed by person other than the patient, identify relationship and authority to do so below.)

Legal Authority: _____

Released by (VVH Employee): _____ **Date/Time:** _____

AUTHORIZATION TO RELEASE PATIENT INFORMATION

VALLEY VIEW