Copy (receive a copy of selected documents) OR	Patient Name:		Date of Birth:	
Copy (receive a copy of selected documents) OR				
Information may be disclosed by:   Valley View Hospital 1906 Blake Ave., Glenwood Springs, CO, 81601   FAX: 970-384-8179 Or Medical Records Email: Myportal@vvh.org		ocuments) OR	To Inspect (read and review documents a	t the Hospital)
Valley View Hospital 1906 Blake Ave., Glenwood Springs, CO, 81601   FAX: 970-384-8179 Or Medical Records Finail: Myportal@vvh.org   Foot & Ankle Center   Valley Orthopedic   The Neurology Center   Sitt Medical Center   Gladway-Young Cancer Center   Women's Health   Glastroenterology Center   Sitt Medical Center   Gladway-Young Cancer Center   Roaring Fork Family Practice   Health   Glastroenterology Center   Sitt Medical Center   Gladway-Young Cancer Center   Roaring Fork Family Practice   Eagle Valley Family Practice   Health   Gladway-Young Cancer Center   Roaring Fork Family Practice   Eagle Valley Family Practice   Eagle Valley Family Practice   Eagle Valley Family Practice   State (State type(s) of Service and/or Condition(s) Treated:   Eagle Valley Family Practice   Email:   State (State type(s) of information that may be disclosed.   Discharge Summary   Emergency Room   History & Physical   Consultation Reports   Operative Reports   Rehab Services   Laboratory Results/Pathology/Slides   Nursing Notes   Muring Notes		ocuments) OK	10 Inspect (read and review documents a	it the Hospital)
Heart & Vascular Center	· ———	Glenwood Springs, CO	, 81601 <b>FAX: 970-384-8179</b> Or Medical Records E	mail: Myportal@vvh.org
Address	] Foot & Ankle Center [ ] Valley Or ] Heart & Vascular Center [ ] Calaway- ] The Spine Center [ ] Rocky Mo ] The Lung Center [ ] Roaring F	thopedic Young Cancer Center ountain Urology	[ ] The Neurology Center [ ] Silt Medi [ ] Women's Health [ ] Gastroent [ ] Internal Medicine	cal Center
3. Information to be disclosed. Date(s) of Service and/or Condition(s) Treated:  4. State type(s) of information that may be disclosed.  Discharge Summary	2. Information may be disclosed to:	Phone:		
A State type(s) of information that may be disclosed.  Discharge Summary		Address:	Email:	
Discharge Summary Emergency Room History & Physical Consultation Reports Operative Reports Rehab Services Laboratory Results/Pathology/Slides Nursing Notes Medication Records Physicians Orders Physician Progress Notes Billing records X-Ray Reports X-Ray Images Diagnostic Test Reports Clinic Provider Notes Other (please specify):  5. (initials) IDO[] or IDO NOT[] consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, Genetic testing/results, Sickle cell anemia testing/results.  *** NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. *** 6. Purpose for disclosure:  Further Medical Care Insurance Eligibility/Benefits Personal Legal Investigation or Action Billing Other:  7. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse. This information in tom tomatical to from records whose confidentiality may be protected by State andre Federal law.  8. I understand that your facility may receive compensation for medical record copying in accordance with State law.  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 of or 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 d		Treated:		
Operative Reports	4. State type(s) of information that m	ay be disclosed.		
Medication Records	Discharge Summary	Emergency Room	History & Physical	Consultation Reports
X-Ray Reports   X-Ray Images   Diagnostic Test Reports   Clinic Provider Notes	Operative Reports	Rehab Services	Laboratory Results/Pathology/Slides	Nursing Notes
Other (please specify):    Consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, Genetic testing/results, Sickle cell anemia testing/results.  ***NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. ***    Further Medical Care	Medication Records	Physicians Orders	Physician Progress Notes	Billing records
Consent to release of information relating to psychiatric or psychological testing or treatment, alcohol and/or drug abuse diagnosis, prognosis and treatment and/or HIV (AIDS) testing and/or results, Genetic testing/results, Sickle cell anemia testing/results.  *** NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. ***    Further Medical Care	X-Ray Reports	X-Ray Images	Diagnostic Test Reports	_ Clinic Provider Notes
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<ul> <li>7. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol abuse. This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.</li> <li>8. I understand that your facility may receive compensation for medical record copying in accordance with State law.</li> <li>9. 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. 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 of or 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.</li> <li>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 #7 above.</li> <li>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. I must do so in writing and present my written revocation to the Health Information Management Department. I 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 author</li></ul>	Other (please specify):  [Initials] I DO [ ]  relating to psychiatric or psycholog (AIDS) testing and/or results, Gene	ical testing or treatme tic testing/results, Sic	ent, alcohol and/or drug abuse diagnosis, prognos kle cell anemia testing/results.	
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## HOW TO COMPLETE AN AUTHORIZATION TO RELEASE PATIENT INFORMATION

The items below are a description of each element on the authorization. Please read carefully and complete the authorization accordingly.

Please fill out the gray area at the top of the page to include: Patient Name, Date of Birth, Address, Phone Number, Email and Fax Number.

You can fax, email, mail or drop off the completed form to the Medical records department at Valley View. Fax number 970-384-8179, Email Myportal@vvh.org, address 2001 Blake Ave Suite 1A GWS, hours M-F 8-4:30.

## INFORMATION TO BE DISCLOSED BY:

Please indicate to whom you would like the information to be disclosed by: Valley View Hospital or other Name/Facility indicated.

## **INFORMATION MAY BE DISCLOSED TO:**

Please indicate to whom you would like the information to be disclosed and the complete mailing address with phone number.

#### **INFORMATION TO BE DISCLOSED:**

Please indicate the period of healthcare services and check the specific information that you would like disclosed. In 3.1(A), initial and check whether you consent to the release of the sensitive health records identified. Please Note: If this section is not completed, then records of this type, if they exist, will not be released.

#### FOR THE PURPOSE OF:

Please check the appropriate box to indicate why the information is needed or check the "other" box and write in the reason on the blank provided.

#### **EXPIRATION AND REVOCATION:**

Please fill in the time period or event for which you would like this authorization to be valid. Please note that after this time period or specified event, the authorization will no longer be valid and no additional information will be sent.

Please sign and date the authorization. If you are not the patient, please indicate your authority to sign on the "Relationship to Patient" line, e.g., Parent, Durable Power of Attorney, etc.

*Copy service:* Please understand that it may take up to 30 days to receive a copy of your medical record. If you have any questions about this service or the authorization form, please feel free to contact the Health Information Management Department (970) 384-6800 or Email us at Myportal@vvh.org. Thank you.

# AUTHORIZATION TO RELEASE PATIENT INFORMATION



