Patient Name: **Date of Birth:**
Phone Number:
Address:

☐ **Copy** (receive a copy of selected documents) **OR** ☐ **To Inspect** (read and review documents at the Hospital)

1. 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**

[ ] Foot & Ankle Center	[ ] Valley Orthopedic	[ ] The Neurology Center	[ ] Silt Medical Center
[ ] Heart & Vascular Center	[ ] Calaway-Young Cancer Center	[ ] Women's Health	[ ] Gastroenterology Center
[ ] The Spine Center	[ ] Rocky Mountain Urology	[ ] Internal Medicine	
[ ] The Lung Center	[ ] Roaring Fork Family Practice	[ ] Eagle Valley Family Practice	

[ ] Name/Facility:

2. Information may be disclosed to: Name: Fax:
Phone:
Address: Email:

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	_____ 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) **I DO [ ] or I DO 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 is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

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

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.

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.

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

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.