Authorization to Release Protected Health Information

P.O. Box 40,000
Vail, CO 81658
970-569-7403

Please Indicate Location:

- ❑ Vail Valley Medical Center
- ❑ Howard Head Sports Medicine (Location: ____________)
- ❑ Avon Urgent
- ❑ Gypsum Urgent Care
- ❑ Beaver Creek Emergency
- ❑ Shaw Regional Cancer Center
- ❑ Sonnenalp Breast Imaging Center
- ❑ Eagle Valley Pharmacy
- ❑ Edwards Medical Center Pharmacy

Section A: This section must be completed for all Authorizations — **Fax Completed Consent to 970-470-6641**

Patient Name:	**Birth Date:**	**Social Security No.** (*optional):*

Address 1:			**Recipient's Name (Who do you want VVMC to send records to?):**		
Address 2:			**Address 1**:		
City:	**State**:	**Zip**:	**Address 2**:		
Phone:	**Fax:**		**City**:	**State**:	**Zip**:
Email:			**Phone:**	**Fax:**	

This authorization will expire on the following:
Date, Event or Condition: ___________________________
If expiration date, event, or condition is not specified, this authorization will expire in 90 days.

Purpose of disclosure:

Description of information to be used or disclosed

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
☐ All PHI in Medical Record	_________	☐ Chemotherapy / Radiation Therapy Notes / Reports	_________	☐ Pap Smear Results	_________
☐ Admission Forms	_________	☐ Medication Sheets	_________	☐ Cardiology Reports	_________
☐ ED /Urgent Care Physician Notes	_________	☐ Operative Reports	_________	☐ EKG/ EKG Rhythm Strips	_________
☐ Physician Orders	_________	☐ Transfer Forms	_________	☐ Laboratory / Pathology Reports	_________
☐ Physician Progress Notes	_________	☐ Discharge Instructions	_________	☐ Pathology Slides	_________
☐ Physical Therapy Notes	_________	☐ Breast Studies	_________	☐ Itemized bill:	_________
☐ Labor & Delivery Summary	_________	☐ Imaging Reports	_________	☐ UB-92 / HICF 1500:	_________
☐ Postpartum flow sheet	_________	☐ Imaging films /CD (specify tests): _________________	_________	☐ Other: _____________	_________

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ______________ (Initial) If not applicable, check here. ☐

I understand that:

- I may refuse to sign this authorization and that it is strictly voluntary.
- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing. If I choose to revoke this authorization, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I get a copy of this form after I sign it.

Section B: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

FOR VVMC USE ONLY

Date Information Released:	Medical Record Number / CD #:
Information Released by:	Number of Pages Released: