VAIL HEALTH

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION (MEDICAL AND BILLING RECORDS)

Vail Health includes services of Vail Health Hospital

PATIENT INFORMATION

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

RELEASE MEDICAL RECORDS FROM:

_____
Doctor/Hospital/Facility

_____
Street Address/City/State/Zip Code

_____
Phone No. (Identify country) / Fax Number

SEND MEDICAL RECORDS TO:

_____
Doctor/Hospital/Agency/Facility/Person

_____
Street Address/City/State/Zip Code

_____
Phone No. (Identify country) / Fax Number / Email

Send my records via: ❑ USPS (____Paper,____ Encrypted CD,____Unencrypted CD) ❑ Secured Email
❑ Unsecured Fax Line ❑ Edwards pick up ❑ Vail pick up ❑ Verbal Authorization only

Sensitive Data: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.
❑ I Authorize Release; ❑ I Do Not Authorize Release; ❑ This is not applicable to me.

INFORMATION TO BE RELEASED:
From Dates of Service (Month /Day/Year):_____/_____/_____ to _____/_____/_____

❑ Abstract (see back of form) ❑ History/Physical ❑ Physical/Speech/Occupational Therapy
❑ Radiology/X-ray Reports ❑ Films/Images on CD-ROM ❑ Pathology Slides
❑ Emergency Room/Urgent Care Record ❑ Chemotherapy/Radiation ❑ Laboratory Reports
❑ Outpatient/Clinic Notes (specify physician/clinic):_____ ❑ Immunization Records
❑ Labor and Delivery Summary ❑ Cardiology Procedure ❑ Operative Report ❑ Discharge Summary
Billing Information: ❑ Standard **or** ❑ Itemized Bill ❑ Other Records (please specify): _____

INFORMATION TO BE USED FOR: ❑ Continuity of Medical Care ❑ Damage/Claim/Insurance Information
❑ Personal ❑ Attorney/Legal ❑ Workers Compensation/Disability ❑ Other: _____

Authorization for the use of Disclosure of Protected Health Information:

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 60 days.** I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. **I have read the above and authorize the disclosure (release) of my medical or billing records as stated above.**

_____ _____
Signature of Patient/Patient Representative **Date**

_____ _____
Printed Name of Patient/Patient Representative **Relationship to Patient**

You are entitled to receive a copy of this Signed Authorization

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Additional Information Regarding Your Request

I understand that this authorization is voluntary and that Vail Health will not base treatment, payment, enrollment, or eligibility for benefits on my signing of this document. Patient initials here: _____

Requesting medical records on behalf of another person: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir At Law, etc. Please contact **Medical Records at 970-569-7403** to determine the documentation that you will be required to process your request.

Requesting your records at the conclusion of your visit or while you are still a patient in the hospital: If you are requesting during your hospital stay or at the conclusion of your visit, please be aware that there may be outstanding reports/documentation that may not be finalized at the time you receive the records you have requested. The records you receive should be considered incomplete and preliminary.

Turnaround time: Our average turnaround time for processing requests is 10 (ten) business days plus shipping time. However, it may require 30 or more days to complete your request. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your phone number on your request, in case we need to contact you for additional information. For questions regarding requests for medical record copies, please contact Vail Health at 970-569-7403.

Picking up your records: If you personally pick up your records or if you send a designee to pick up your records, **a photo identification (**driver's license, passport, etc.) will be **required** before the records are released.

Designee's Name as it appears on Driver's License: _____

Abstract of Medical Records includes – Laboratory results, Imaging Reports, Imaging disc, History & Physical, Consultations, Discharge Summary, ED Physician note, Urgent Care Physician note, Cardiology Procedures, Operative Reports when applicable.

Vail Location
Vail Health: PO Box 40,000, Vail Co. 81658
181 W. Meadow Dr, Vail, Co. 81657,
Hours: 8 a.m.-4:30 p.m.
Tel.: (970) 477-3093 **Fax:** (970) 470-6600

Edwards Location
320 Beard Creek Road (rear of bldg), 2nd Fl., Edwards, Co. 81632
Hours: 8 a.m-4:30 p.m.
Tel: (970) 569-7403 **Fax:** (970) 470-6641

Email: Medical.Records@vailhealth.org

For VAIL HEALTH use Only:

Date Request Recvd:	**Med. Rec. released by:**	**CD released by:**	**Completion Date:**
Incomplete: Yes / No	**What was released:**		**Log date:**
MRN/ FIN:	**# of pages:**		**# of films:**

You are entitled to receive a copy of this Signed Authorization