

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Release To:	Release From:
_____ Name of Person, Company, or Organization	_____ Name of Person, Company, or Organization
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Telephone Number	_____ Telephone Number
_____ Fax	_____ Fax

Method of Release:  In Person  Fax  By Mail

I authorize the use or disclosure of the above-named individual's health information, as described below:

**The Following Information is to be Disclosed (please check all that apply):**

- Radiology Reports Only  Radiology Images Only  Radiology Reports & Images (please allow 48 hours notice)
- Laboratory Tests  ER Report
- Other Medical Records or Health Information: \_\_\_\_\_

### Sensitive Information:

- I understand that the above-mentioned records may include information relating to (check to authorize release):
- Acquired Immune Deficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
  - Med/Psych Rehabilitation  Sexually Transmitted Disease(s)
  - Diagnosis/Treatment for Alcohol and/or Drug Use  Information for Research Purposes

Date or date range that services were provided: \_\_\_\_\_

### Purpose of This Request:

- Continued Care  Personal Use  Other (specify): \_\_\_\_\_

### Disclosure:

I understand that any disclosure of medical information carries with it the potential for re-disclosure, and that the recipient may not be governed by the federal privacy and confidentiality legislation.

### Right to Revoke:

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization I must do so in writing and present my written revocation to the Director of Health Record Information Services or the Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

### Expiration:

Unless otherwise revoked, this authorization will expire on the following date, event or condition: \_\_\_\_\_. If I do not specify an expiration date, event or condition, this authorization will expire upon release of the information requested, or 120 days from the date of signing.

- If I have questions about disclosure of my health information, I can contact the Privacy Officer at (970) 644-3030 or the Compliance Officer at (970) 644-3030.
- I understand that I may request a copy of this authorization form, after signing. I understand that I need not sign this form in order to receive healthcare treatment.

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If Signed by Legal Representative, Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness (not required): \_\_\_\_\_ Date: \_\_\_\_\_

- Checked I.D.