



23500 U.S. Highway 160 West
 Walsenburg, CO 81089
 Telephone 719-738-5204 | 719-738-4586
 Fax 719-738-5760

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Released from: Spanish Peaks Regional Health Center			Released to:		
			<input type="checkbox"/> Patient <input type="checkbox"/> Other Person/ Relationship: _____ <input type="checkbox"/> Other Facility		
_____ Patient Name			_____ Other Person or Other Facility Name		
_____ Mailing Address			_____ Mailing Address		
_____ City	_____ State	_____ Zip	_____ City	_____ State	_____ Zip
_____ Phone		_____ Fax	_____ Phone		_____ Fax
Patient's Date of Birth: _____			Patient: <input type="checkbox"/> Pick Up <input type="checkbox"/> Fax <input type="checkbox"/> Mail		
Email Address: _____			Other Person: <input type="checkbox"/> Pick Up <input type="checkbox"/> Fax <input type="checkbox"/> Mail		
			Facility: <input type="checkbox"/> Fax <input type="checkbox"/> Mail		
<input type="checkbox"/> New <input type="checkbox"/> Updated					

INFORMATION TO BE COPIED AND RELEASED (CHECK ALL THAT APPLY):

Date(s) of service: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Nurses Notes | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Rehab Services |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Lab/Pathology Results | <input type="checkbox"/> Patient Care Photos |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Radiology Report | <input type="checkbox"/> Non-SPRHC Medical Records |
| <input type="checkbox"/> Physician Progress Notes | <input type="checkbox"/> Radiology Images | <input type="checkbox"/> Other (specify) _____ |

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.*****

THE PURPOSE FOR THIS RELEASE:

<input type="checkbox"/> Continuity of Medical Care	<input type="checkbox"/> Damage/Claim Information	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Legal
<input type="checkbox"/> Other: _____			

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge incomplete forms cannot be processed and there may be a cost to copy these records.

I understand **this consent expires one year from the date of my signature** unless otherwise specified as follows: _____
 I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original. **Please retain a copy of your records for your personal use.**

~~~~~PLEASE ALLOW 10 BUSINESS DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED.~~~~~

|                                                                 |           |                      |           |
|-----------------------------------------------------------------|-----------|----------------------|-----------|
| Signature of Patient/Representative                             | Date/Time | Signature of Witness | Date/Time |
| <b>Name of SPRHC Staff person who released medical records:</b> |           | <b>Date:</b>         |           |

|                                                        |                        |                        |              |
|--------------------------------------------------------|------------------------|------------------------|--------------|
| <b>OFFICE USE ONLY: Proof of Identification:</b> _____ |                        |                        |              |
| Number of pages released: _____                        | Completion date: _____ | Delivery method: _____ |              |
| Name of individual who received request: _____         | Date received: _____   |                        |              |
| Patient Medical Record Number / Account Number: _____  |                        |                        | REV/JAN 2018 |