AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PROVIDER_____
Name & Address of Health Care Facility

PATIENT_____SSN:_____DATE OF BIRTH: _____

RELEASE TO: _____
Name & Address of Recipient Agency, Organization or Individual to whom information is to be released

GENERAL AUTHORIZATION: I authorize the above named health care provider to release the information specified below to the organization, agency or individual named on this request.

INFORMATION REQUIRIED:
(Initial as appropriate)
( ) Copy of History & Physical, Discharge Summary & Operative Reports
( ) Copy of Outpatient date/ E.R. date records
( ) Copy of complete medical record
( ) Copy of Electronic Discharge Instructions
( ) Other (Specify):_____

CONDITION(S) & DATES OF CARE
(Initial as appropriate)
( ) All past admissions or care at this facility provides as of the dates of my signature
( ) Limited to treatment dates & for conditions described here: _____

Without my previous express revocation, this authorization will automatically expire:
(Initial One)
( ) On_____(date specified by patient);
( ) 180 days from the date of my signature;
( ) Upon fulfilling the purpose or need for information as specified above, but no longer than _____days (to be supplied by the patient) from the date of signature:_____
Date of Signature

SPECIFIC AUTHORIZATION: I specifically authorize the release of information regarding the following condition(s):
(Initial as appropriate)
( ) Drug Abuse ( ) Alcohol Abuse ( ) Psychological or Psychiatric Conditions
Alcohol or Drug Abuse Statement must be attached to any disclosure of this information from a federally assisted alcohol or drug abuse program. Any oral disclosure shall be accompanied or followed by such statement.
Program name if applicable: _____or N/A.
Note: Federal regulations require consent to release alcohol or drug record last no longer than reasonably necessary to serve the purpose for which the release is given.

USE OF COPIES: A copy of this authorization with my signature thereon (initial one) ( ) MAY; ( ); MAY NOT be used with the same effectiveness as an original.

_____ _____
Signature of Patient or Authorized Representative Date

If signed by an Authorized Representative:

_____ _____
Print or Type Authorization Representative's name State How Authorized

San Luis Valley Health is not responsible if lost

Refer questions to: 719-587-1392

San Luis Valley Health-RMC
106 Blanca Ave.
Alamosa, CO. 81101

San Luis Valley Health-CCH
19021 US Highway 285
La Jara, CO. 81140

Patient Sticker

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