

# AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

RELEASE FROM: \_\_\_\_\_  
Name, Address, Phone and/or Fax Number of Health Care Facility Releasing Information

PATIENT \_\_\_\_\_ SSN: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

RELEASE TO: \_\_\_\_\_  
Name, Address, Phone and/or Fax Number of Recipient Agency, Organization or Individual to whom information is to be released to

**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 REQUIRED:

(Initial as appropriate)

- Copy of E.R./Inpatient Reports and Records
- Copy of Outpatient Results/Clinic Records
- Copy of complete medical record
- Last 2 years of records for transfer of care
- Other (Specify): \_\_\_\_\_

## CONDITION(S) & DATES OF CARE

(Initial as appropriate)

- All past admissions/dates of treatment at this facility
- Limited to the following treatment dates:  
From: \_\_\_\_\_ To: \_\_\_\_\_

**Without my previous express cancellation, this authorization will automatically expire in 1 year unless noted otherwise below:**

(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: \_\_\_\_\_.

## SPECIFIC AUTHORIZATION: (Initial as appropriate)

I specifically authorize the release of information regarding the following condition(s):

- Drug Abuse
- Alcohol Abuse
- Psychological or Psychiatric Conditions

**Note:** Federal regulations require consent to release alcohol or drug records lasting no longer than reasonably necessary to serve the purpose for which the release is given.

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.

## USE OF COPIES:

A copy of this authorization with my signature thereon ( ) 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

**PLEASE EMAIL RECORDS IF POSSIBLE TO:**  
[MRChartPullRequest@slvrhc.org](mailto:MRChartPullRequest@slvrhc.org)

Patient Sticker



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

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