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 REQUIRIED:
(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: 719-587-1391

PLEASE EMAIL RECORDS IF POSSIBLE TO:
MRChartPullRequest@slvrmc.org

Patient Sticker

San Luis Valley HEALTH

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

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

000700 (09-22)