Mountain Family Health Centers
Health Records Management
PO Box 339, Glenwood Springs, CO 81602
PHONE: (970)945-2840FAX (970) 945-1055

Authorization for Use and Disclosure of Personal Health Information

RECORDS RELEASE

Patient Name: _____ Date of Birth: _____/_____/_____ MRN_____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Email:_____

I request that my protected health information (PHI) FROM Mountain Family Health Centers be disclosed to/from:
Recipient/Provider Name: _____DOB:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax _____ Email:_____

I request that my protected health information (PHI) TO Mountain Family Health Centers from:

Releasing Provider Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax _____

I authorize the following PHI to be released from my medical record(s):
_____Complete Medical Record (all pages) **Specify dates of service:**_____**to**_____

_____Dental Records _____ Immunization Record ___Radiology Report(s) _____Lab/Pathology Reports

_____Billing/Financial Information _____ Medication List Other_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired or mental health services, and treatment of alcohol or drug abuse. *State and federal law protects this information. If this information applies to you, please indicate if you would like this information released/obtained: PATIENT MUST CONFIRM OR DENY BY INITIALING YES OR NO*

Alcohol, Drug, or Substance Abuse Records ____Yes ____No
HIV Testing and Results ____ Yes _____No
Mental Health Records ____ Yes _____No
Psychotherapy Records ____ Yes _____No
Sexually transmitted diseases ____ Yes _____No

Purpose for requesting information:
____Personal Use ___Legal ___Transfer of Care if yes, please indicate €Moved €Access to Care €Dissatisfied
Disclosure Format (Paper is default if not marked.): € US Mail €Fax €Flash drive € Email € Patient Portal
By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to Health Records Mgmt. Manager at PO Box 339, Glenwood Springs, CO 81602 Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____
  If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

_____ _____
Print Name Relationship to Patient (if applicable)

Records will be released within 5 business days. If you have an urgent situation, please notify a staff member. If request is being mailed or faxed, please attach a copy of your picture ID.

IF ANY PART OF THIS FORM IS FILLED OUT INCORRECTLY, THE REQUEST WILL BE DENIED AND THE RECORDS WILL NOT BE RELEASED UNTIL CORRECT WHICH MAY CAUSE A DELAY IN YOUR REQUEST.