Valley-Wide
Health Systems, Inc.
128 Market Street
Alamosa, CO 81101

COMPLETE TRANSFER OF CARE AUTHORIZATION TO DISCLOSE PATIENT HEALTH INFORMATION (PHI)

1. I authorize Valley-Wide Health Systems to release the health information of the individual named below.

   Patient Name: _____

   Address: _____

   Phone#: _____ Date of Birth____/_____/_____

2. I authorize the information to be disclosed to and used by the following individual or organization.

   Name:_____

   Address:_____

   City: _____ State:_____ Zip Code:_____

   Phone#:_____ Fax#: _____

3. The type of information to be disclosed as follows:

   ☐ Complete Transfer of Care (Records will be transferred within 72 hours of receiving request)
   ***Records sent to another medical office will be provided at no charge** ***

Initial

____ **I understand that a complete transfer of care means I am no longer a patient of Valley-Wide Health Systems, Inc.**

____ **I understand that any currently prescribed medications will be stopped and marked inactive in my VWHS chart**

____ **I understand I will no longer receive prescription refills for any stopped or inactive medications after 45 days from the date of this form to ensure proper transition of care.**

____ **I understand that if I wish to return to VWHS, I will have to establish with a primary care provider who is accepting new patients. Convenient care visits do not count as reestablishing primary care with VWHS but I can still seek care for emergent conditions.**

____ **I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.**

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____ _____
Personal Representative's Name (print) and Relationship Date
(please attach applicable legal documentation of authority)

For Office Use Only:

Person Number:_____ Verified by:_____ Date: _____