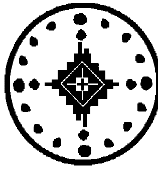

# Valley-Wide Health Systems, Inc.

128 Market Street
Alamosa, CO 81101

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 ______________________________ Person Number ______________________
   Address: ______________________________________________________________________
   Phone#: ________________________________ Date of Birth____/_____/____SSN:____________
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 and amount of information to be disclosed is as follows: (specify dates where appropriate)

☐ Medication List
☐ Immunization Record
☐ Most Recent Lab
☐ Most Recent X-Ray
☐ Most Recent Office Visit

☐ Specific Date of Service __/__/__
☐ Specific Date Range**:**
__/__/__ **to** __/__/__
☐ Other: ________________________
☐ Entire Medical Record (includes CCR*)
☐ Complete Transfer of Care (includes CCR)

**Purpose of Disclosure**____________________
**Approving Provider Signature** **Date**
______________________________________

Please select how you would like to receive your records:
☐ Electronic Format (CD) (**$15 Fee**)
☐ Paper Format (**Per Page Fee**)
$16.50 pgs 1-10, $.75 pgs 10-40, $.50 pgs over 40
☐ Secure Email (**$15 Fee**)
Email Address:_________________________
**Records sent to another medical office will be provided at no charge.**

* Definition of Continuity of Care Record (CCR) – Electronic Summary of partial or all medical information contained within the electronic health record. Designed to allow ease of transfer of care from one entity to another and could potentially be imported into another electronic health record.

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4. 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.
5. I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand the revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
6. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. VWHS cannot condition treatment, payment, and enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7. I accept full financial responsibility for copying fees.

______________________________________ ___________________
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:
Verification of Photo ID _________________________ Verified by_____________ Rev. 5-12, 1-14