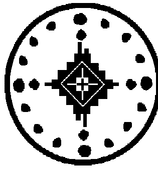

Valley-Wide Health Systems, Inc.

128 Market Street
Alamosa, CO 81101

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize_____________________________________,Address:_________________________________
____ Phone:(   )______-_______Fax:(   )______-______
to release the health information of the individual named below:
Patient Name: ____
Address: ____
Phone#: ___________________________________Date of Birth:____/_____/____SSN:____________

2. I authorize the information to be disclosed to and used by the following individual or organization.
Name: Valley Wide Health Systems Inc. ____
Address: 128 Market Street ____
City: Alamosa ____________________State: CO ____________Zip Code: 81101 __________________
Phone:# (719) 589-5161 __________________Fax:# (866) 257-8195 ______________________

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

Purpose of Disclose:
____

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. 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.

______________________________________ ___________________
Signature of Patient or Authorized Personal Representative Date

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