



181 Meadow Drive Vail, CO 81657

Consent/Authorization to Release Health Information

PATIENT INFORMATION		PLEASE RETURN BY FAX TO 970-470-6641	
Patient's Last Name:		Birth date:	
First:		Middle:	
Street Address:		Social Security No.:	
P.O. Box:		Home Phone No.:	
City:		()	
State:		ZIP Code:	
INFORMATION			
<input type="checkbox"/> Consult <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Emergency Dept Rpt <input type="checkbox"/> EKG Tracings <input type="checkbox"/> Graphic Record <input type="checkbox"/> History & Physical		<input type="checkbox"/> Labs <input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> MRI Report <input type="checkbox"/> Operative Report <input type="checkbox"/> X-Ray Report <input type="checkbox"/> X-Ray MRI	
Date of Service		Purpose of Release:	
<input type="checkbox"/> Other as specified below:			
This Consent/Authorization is to release health information to:			
Name		Phone No.:	
Address		City	
		State	
		Zip	
This Consent/Authorization will remain in effect:			
<input type="checkbox"/> From the date it is signed until:			
<input type="checkbox"/> Until the following event occurs:			
<small>Note: if neither of the above options is selected, this Consent/Authorization will remain in effect for 180 days from the date that it is signed.</small>			
I authorize Vail Valley Medical Center to release the health information described above and understand that:			
<ol style="list-style-type: none"> 1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric conditions, unless restricted as follows: 2. Once information is disclosed pursuant to this signed Consent/Authorization, I understand that the federal privacy law (45 C.F.R parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. 3. I may revoke this Consent/Authorization at any time, except to the extent that action has been taken in reliance on it. To revoke it, I must provide the Privacy Officer – at the address listed at the top left of this form – with a written revocation which will not be effective until received and approved by the Privacy Officer. 4. I may refuse to sign this Consent/Authorization and this refusal will not affect the Treatment Vail Valley Medical Center provides to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party. 			
Signature of Patient/Parent or Legal Representative			Date
If signed by Legal Representative, Legal Representative's authority to act on behalf of patient:			
Relationship to patient:			
For Office Use Only			
Date Information Released		Medical Record Number	
Information Released by:			