



# Family Health West

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Fruita, CO 81521 + Fax (970) 858-2157  
+ Health Records Dept. (970) 858-2121

Name \_\_\_\_\_  
Patient # \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Phone \_\_\_\_\_ day \_\_\_\_\_ evening

## AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I authorize the following individual or organization:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To release information to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Mail/fax records requested.

Call me when records are ready to be picked up.

Phone #: \_\_\_\_\_

Allow my designated representative to pick up.

Name: \_\_\_\_\_

Other (specify) \_\_\_\_\_

### Please release the following information:

Complete Medical Record	Laboratory Reports
Admission #:	Doctor's Orders
Discharge Summary	Doctor's Notes
Therapy Notes: PT ST OT	Medication List
History & Physical	Consultation Reports
Treatment Dates:	X-Ray Reports
Other:	

Release of records is for the purpose of :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marketing that involves payment  
 At the request of the individual

I request and authorize the release of information to the individual or organization named above. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire in 6 months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I may contact the Privacy Officer.

Date \_\_\_\_\_ Signature of Patient / Guardian / Power of Attorney \_\_\_\_\_ Description of your authority to represent the individual \_\_\_\_\_

Witness \_\_\_\_\_ Title \_\_\_\_\_ ID / Driver's License \_\_\_\_\_ Authorization Revoked \_\_\_\_\_

Records Copied and Released By \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_ Original to Health Records Dept. Revised: 2/17/03