**MidValley Family Practice PC**

1450 East Valley Road Suite 102, Basalt CO 81621

970-927-4666 Phone

970-927-6623 Fax

**Authorization to Release Medical Records**

**Patient Name Date of Birth**

**Please send my records □ to MidValley Family Practice □ from MidValley Family Practice**

***I Hereby Authorize***

**Name Address Phone Fax**

|  |  |  |  |
| --- | --- | --- | --- |
| MidValley Family Practice | 1450 E. Valley Rd #102  Basalt, CO 81621 | 970-927-4666 | 970-927-6623 |

***And***

**Name Address Phone Fax**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

***To Share The Following Health Information***

|  |  |
| --- | --- |
| **PLEASE INITIAL NEXT TO THE SPECIFIC TYPE OF HEALTH HISTORY:**  Only records generated by this facility  \_\_\_\_\_\_\_\_\_ Lab Reports  \_\_\_\_\_\_\_\_\_ Imaging Reports  All medical records at including records from other facilities  Specific Dates/Tests Only | **PRIVILEGED INFORMATION:**  *In compliance with Colorado statutes, which require special permission to release privileged information, please release the records only pertaining to the below as initialed:* |
| \_\_\_\_\_\_ Mental health  \_\_\_\_\_\_ Drug Abuse  \_\_\_\_\_\_ HIV (AIDS)  \_\_\_\_\_\_ Communicable Diseases  \_\_\_\_\_\_ Alcoholism  \_\_\_\_\_\_ Child Abuse  \_\_\_\_\_\_ Sexually Transmitted Diseases  \_\_\_\_\_\_ Cancer |

**Purpose for disclosure:**

**\_\_\_\_\_\_\_\_\_ Transferring Care \_\_\_\_\_\_\_\_\_\_Continuing Treatment and/or Consultation \_\_\_\_\_\_\_\_\_\_ To hold verbal discussion**

**\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MY AUTHORIZATION IS GIVEN FREELY WITH THE UNDERSTANDING THAT:**

1. Except as otherwise permitted or required a covered entity may use or disclose PHI that is valid. When a covered entity obtains/receives a valid authorization for its use or disclosure of protected health information (PHI), such use of discloser must be consistent with such authorize. 45 CFR (c) 2
2. I may revoke with authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing. MVFP will not change my treatment because of a signed release.
3. The authorization for release may include records which may include the presence of a communicable or non communicable disease. I understand that the records requested may be protected under 42 CFR Part 2 governing Alcohol and Drug Abuse patient records, the Health Insurance Portability Accountability Act of 1996 (“HIPAA”), 45 CFR Parts 160 & 164, State Confidentiality laws and regulation and cannot be released without my consent unless otherwise provided for regulations. State and Federal Law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulations.
4. A photo copy or fax of this authorization is as valid as the original.
5. MFVP, its directors, officers, employees, agents, and volunteers are here by released from any legal responsibility of liability for disclosure of the above mentioned information to the extent indicated and authorized herein.
6. I am responsible for any fees associated with releasing my medical information.

MVFP Office Use

\_\_\_\_\_date release sent

\_\_\_\_\_ date records sent

\_\_\_\_\_ date records received

**Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person Authorized to sign for Patient Name/Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Person Authorized to sign for Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**