AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
Release Records - from Pagosa Springs Medical Center

I, (First Name Last Name) _____ Date of Birth _____
Address_____ Phone_____
hereby authorize Pagosa Springs Medical Center (PSMC) to release my protected health information described below which may include information concerning treatment for drug or alcohol use, psychiatric treatment, HIV/AIDS/ARC status or genetic testing to:
A separate form is required for each disclosure or use.

I authorize the following person(s), including Self, or organization to receive the information:
Name _____ **Address** _____
City _____**State** _____ **Zip** _____ **Fax** _____ **Phone**_____
To the Attention of_____

Dates requested:_____ **Purpose:**_____

_____ Abstract (including all doctor notes, ex-ray and lab reports)
_____ Complete medical record (including Abstract, nursing notes, vital signs, daily assessments, etc.)

_____ Discharge Summary	_____ Emergency Record	_____ Laboratory Report
_____ Physician Progress Note	_____ Clinic Note	_____ Radiology/Imaging Report
_____ Operative Report	_____ EKG/Stress Test	_____ Radiology Disc
_____ Consultation Report	_____ Physical Therapy Note	_____ Immunization Record

_____ Other: _____

If my initials appear below, I request that you DO NOT send the following records:
_____ I do not authorize release of any records concerning drug or alcohol treatment and/or psychiatric treatment.
_____ I do not authorize the release of any records concerning genetic testing for the purposes set forth above.
_____ I do not authorize release of any records concerning my diagnosis of or treatment for HIV, AIDS, ARC, or contain some other reference to my identity as an HIV, AIDS, or ARC patient for the purpose set forth above.

This authorization will expire on (date or event):_____. If no date or event is specified, the authorization shall expire once the purpose stated above is served.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that I may inspect or copy the protected health information described in this authorization.

I understand that this authorization may be revoked at any time by notifying PSMC in writing to: Pagosa Springs Medical Center (95 S. Pagosa Blvd, Pagosa Springs, CO 81147), and that PSMC must cease using this authorization, except that PSMC may complete any actions it initiated in reliance on this authorization and prior to my revocation.

I understand that PSMC shall not condition treatment, payment or enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure and that I may refuse to sign this authorization.

I understand that by authorizing this release of my medical records, I also release PSMC from all legal responsibility or liability that may arise from the release of my protected health information.

_____ _____
Signature of Individual or Personal Representative Date

_____
Authority of Representative **(**parent of minor, guardian, etc.)

Identification Verified By: _____ (Signature of PSMC Staff)

__Will Pick Up Records (please allow 10 business days), ___ Mail Records, ___ Fax Records to number supplied above

PAGOSA SPRINGS
Medical Center
Reviewed/Revised 9/24/2014, 10/29/2014 05/26/2016