AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION -OTHER ENTITY

Request Records – send to Pagosa Springs Medical Center

I, (First Name Last Name) ____ Date of Birth _________________________
Address____ Phone_______________________________
hereby authorize release of 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 FROM:

Provider Name_____________________________________ **Practice Name**_______________________________________

Address____

City____ **State**______________________ **Zip Code**________________

Fax Number______________________________________ **Phone Number**____

A separate form is required for each disclosure or use.

I authorize the following person(s) or organization to RECEIVE the information:

Name: Pagosa Springs Medical Center
Address: 95 South Pagosa Blvd.
City: Pagosa Springs, CO 81147
Phone: 970-507-3828 **Fax: 970-731-1915 to the attention of: Medical Records**

Date(s) of Service:____________________________ **Purpose:**____

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

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 six months from the date it was signed.

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.

____ ____
Signature of Individual or Personal Representative Date

____
Authority of representative (parent of minor, guardian, etc)

Identification Verified By: ____ (Signature of PSMC Staff)

PAGOSA SPRINGS
Medical Center
Reviewed/Revised 10/29/2014, 5/25/2016, 9/30/2016, 12/6/2017