GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

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MEDICAL RECORDS RELEASE

Patient Name _____ SSN # _____

Address _____ Date of Birth _____

City/State/Zip _____ Phone # _____

I Hereby Authorize: (records to be obtained from)

_____
Print name of Doctor or Facility

_____
Address

_____
City/State/Zip

_____ _____
Phone Fax

Release To:

_____
Print Name of Doctor or Facility

_____
Address

_____
City/State/Zip

_____ _____
Phone Fax

_____
Date of next appointment (for which records will be required)

The specific information to be disclosed is:

[ ] Physician's chart notes
[ ] X-ray reports
[ ] Ultrasound report
[ ] Pathology reports
[ ] Current medications
[ ] Operative reports
[ ] Laboratory reports
[ ] Clinical summary
[ ] Immunizations
[ ] Other _____
_____
[ ] Information which may not be disclosed _____
_____

Special dates of interest: _____ to _____.

I understand that this authorization is subject to written revocation by me at any time except in those circumstances in which action has been taken in reliance of it.
I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychaitric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment. By signing below, I hereby authorize the disclosure of information about me that is protected under federal law, for the sole purpose and time period designated. I understand that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law.

I understand this authorization will expire one year from the date signed unless otherwise specified:

_____
Expiration Date

_____ _____
Patient Signature or Personal Representative Date

As a personal representative, I have authority to act for the individual because I am:

_____