GUNNISON VALLEY FAMILY PHYSICIANS
CERTIFIED AMERICAN BOARD OF FAMILY PHYSICIANS

Medical Records

Release Authorization

130 E. Virginia Avenue, Gunnison, CO 81230 • Phone: (970) 641-0211 • Fax: (970) 641-1268
214 6th Street, Suite #1, Crested Butte, CO 81224 • Phone: (970) 349-6749 • Fax: (888) 540-4013

Patient name:_____ DOB:_____

Address:_____ Phone#:_____

City/State/ZIP:_____

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

The specific information to be disclosed is:

- ☐ Provider's chart notes
- ☐ Imaging reports
- ☐ Pathology reports
- ☐ Current medications
- ☐ Operative reports
- ☐ Laboratory reports
- ☐ Consultative reports
- ☐ Immunizations
- ☐ Other_____
- ☐ Billing / Financial records
- ☐ Do not disclose_____

Date of appointment requiring records:_____

Special dates of interest:_____ to_____

I am requesting records for: ☐ Personal use ☐ Continuity of care ☐ Legal use ☐ Switching PCP

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 fees may be incurred for processing my records and that I will be responsible for paying those fees.

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, psychiatric 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:*_____

_____
Signature of patient or personal representative

_____
Date

_____
Printed name of patient or personal representative

_____
Relationship to patient and/or authority to sign for patient (e.g., parent, guardian, power of attorney for health care, executor)