Family Health West

228 North Cherry • P.O. Box 130
Fruita, CO 81521 • Fax (970) 858-2157
Health Records Dept. (970) 858-2120

Name _____

Patient # _____

Date of Birth _____

Social Security # _____

Phone # _____ Day _____ Evening

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I authorize the following individual or organization:

Family Health West

To release information to:

_____ Name

_____ Address

_____ City, State ZIP

_____ Phone # Fax #

☐ Mail/fax records requested.

☐ Call me when records are ready to be picked up.

Phone #: _____

☐ Allow my designated representative to pick up.

Name: _____

☐ Other (specify) _____

Please release the following information:

☐	Complete Chart	☐	Laboratory Reports
☐	X-Ray Reports / CD	☐	Doctor's Orders
☐	Discharge Summary	☐	Doctor's Notes
☐	Therapy Notes: ___PT___ST___OT	☐	Medication List
☐	History & Physical	☐	Consultation Reports
☐	Other:	☐	Operative Report
☐	Treatment Dates:	☐	

Release of records is for the purpose of :

Personal Records

☐ **Marketing that involves payment**

☐ **At the request of the Individual**

I request and authorize the release of information to the individual or organization named above. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the FHW Health Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____. If I fail to specify an expiration date, event, or condition, this authorization will **expire in 6 months**.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I may contact the Privacy Officer.

_____ Date _____ Signature of Patient / Guardian / Power of Attorney _____ Description of your authority to represent the individual

_____ Information received by _____ Title _____ ID / Driver's License _____ Authorization Revoked

_____ Records Copied by – Title _____ Records Released by - Title _____ Date