



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Release of records – **FROM** Family Health West (FHW)

PATIENT: I, (First Name Last name) _____ Date of Birth _____
 Email address _____ Phone _____

hereby authorize Family Health West 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: Name _____ Address _____
 City _____ State _____ Zip _____ Phone _____
 Fax _____ Email _____

Release by method of email fax mail pick up On media type CD USB Paper Due Date _____
 If email, choose: encrypted or unencrypted

Date(s) of Test/Visit _____

Why is the record being requested? _____

Please release the following (select all that apply):

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Emergency Room/Urgent Care	<input type="checkbox"/> Laboratory Report
<input type="checkbox"/> Operative Report	<input type="checkbox"/> EKG/Stress Test Report	<input type="checkbox"/> Radiology Report
<input type="checkbox"/> Sleep Study Report	<input type="checkbox"/> Therapy Note (specify below)	<input type="checkbox"/> Radiology Image (specify below)
<input type="checkbox"/> Clinic Note (specify below)	* Specifically: <input type="checkbox"/> PT <input type="checkbox"/> ST <input type="checkbox"/> OT	* Specifically by: <input type="checkbox"/> email <input type="checkbox"/> USB <input type="checkbox"/> CD
* Clinic name _____	<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Complete 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
- ____ I do not authorize release of any records concerning psychiatric treatment/behavioral health services/counseling services
- ____ I do not authorize release of any records concerning genetic testing
- ____ I do not authorized release of any records concerning my diagnosis of or treatment for HIV, AIDS, ARC, or that contain some other reference to my identity as an HIV, AIDS or ARC patient.

This authorization will 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 receive a copy of the protected information described in this authorization.

I understand that this authorization may be revoked at any time by notifying FHW in writing to: Family Health West ATTN HIMs at 300 West Ottley Avenue, Fruita, CO 81521, and that FHW must cease using this authorization, except that FHW may complete any actions it initiated in reliance on this authorization and prior to my revocation.

I understand that FHW 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 FHW 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, court appointed guardian, medical power of attorney)

 Patient identification verified by (FHW staff) Records released by (FHW staff)

****Please allow 10 business days to process this request.** If required sooner, please specify a due date above.