

Authorization For Use or Disclosure of Medical Record Information

Last Name:	First:	MI:	Da	te of Birth:		
Mailing Address:	C	City:	State: _	Zip:		
Home Phone:	Cell Phone:		Work F	Phone:		
Release Information to: Recipient's Name:			Atter	ntion:		
Mailing Address:	C	City:	State: _	Zip:		
Phone:	Fax:					
Purpose of Request: O Person *Copy Fee: We reserve the	•	•				
Information to be Released: Be Specific if necessary – include dates of treatment & provider name if applicable.						
O Discharge Instructions O Lab Reports	DER Record DER Records DER Records DER Records DER Records DER Records DER Record	•	otes nd Physical	Operative ReportPre-op NotesImaging Report(s)	_	
Delivery Method:	O Diek up	o Mail				
• Discuss Medical Information Expiration Date:	o Pick-up	o Mail				
This authorization is effective thr	ough (check one)	o NO expiratio		d or terminated by the patier	nt or	
** I understand the information in my medical records may contain information related to substance abuse or treatment, mental health, or communicable diseases.						
Patient Signature:				Date:		
Patient/Legally Recognized Representative Signature:						
Date:	Date: Relationship to Patient:					

Know Your Privacy Right, refer to HIPAA "Privacy Notice"

Provide a written statement to the Aspen Mountain Medical Clinic (AMMC) where the Authorization was originally submitted, except to the extent that AMMC has already completed action on it.

^{*}You may revoke this Authorization at any time.

^{**} By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: _____
The information release pursuant to this Authorization may be re-disclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws. AMMC will not condition treatment or payment of provision of this Authorization. Patient does have right to receive a copy of this form.