



## Authorization For Use or Disclosure of Medical Record Information

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

### Release Information to:

Recipient's Name: \_\_\_\_\_ Attention: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Purpose of Request:  Personal  Continuing Care  \*Legal  \*Insurance  \*Other \_\_\_\_\_  
 \*Copy Fee: We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies.

### Information to be Released: Be Specific if necessary – include dates of treatment & provider name if applicable.

Date(s): \_\_\_\_\_  
 Discharge Summary  ER Record  Treatment Plan  Operative Report  
 Discharge Instructions  Medication Records  Office Notes  Pre-op Notes  
 Lab Reports  Consultations  History and Physical  Imaging Report(s)  
 Entire Medical Record  Other: \_\_\_\_\_

### Delivery Method:

Discuss Medical Information  Pick-up  Mail  E-Mail (address): \_\_\_\_\_

### Expiration Date:

This authorization is effective through (check one)  Date: \_\_\_\_\_

If no date is specified, authorization expires one-year from signature.

\*\* 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: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

\*You may revoke this Authorization at any time.

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.

\*\* By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: \_\_\_\_\_  
 Patient does have right to receive a copy of this form.

\*If you want to receive your protected health information via email, it will be sent unencrypted. **NOTE: UNENCRYPTED EMAIL MAY BE AT RISK FOR INADVERTENT DISCLOSURE. BY PROVIDING YOUR EMAIL ADDRESS, YOU ACCEPT THIS RISK.**