SHAW CANCER CENTER
VAIL HEALTH
A service of Vail Health Hospital

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION (MEDICAL & BILLING RECORDS)

PATIENT INFORMATION

Patient Name:	Date of Birth:

RELEASE MEDICAL RECORDS FROM:	SEND MEDICAL RECORDS TO:
Doctor / Hospital / Facility	Doctor / Hospital / Agency / Facility / Person
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code
Phone Number (Indentify country) / Fax	Phone Number (Indentify country) / Fax / Email

SEND MY RECORDS VIA:

☐ USPS (☐ Paper, ☐ Encrypted CD, ☐ Unencrypted CD) ☐ Secured Email ☐ Unsecured Fax Line

☐ Edwards pick up ☐ Vail pick up ☐ Verbal Authorization only ☐ Unsecured Email*

**By selecting Unsecure Email for the transmission of my protected health information, I acknowledge there is an increased risk of my information being intercepted and accessed by someone other than me during the transmission process.*

SENSITIVE DATA: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.

☐ I Authorize Release ☐ I Do Not Authorize Release ☐ This is Not Applicable to Me

INFORMATION TO BE RELEASED:

From Dates of Service (Month/Day/Year): to:

☐ Abstract (see back of form) ☐ History Physical/Consult ☐ Physical/Speech/Occupational Therapy

☐ Radiology/X-ray Records ☐ Films/Imagers on CD-ROM ☐ Pathology Slides

☐ Emergency Room/Urgent Care Record ☐ Chemotherapy/Radiation ☐ Laboratory Reports

☐ Outpatient/Clinic Notes (specify physician/clinic): ☐ Immunization Records

☐ Labor & Delivery Summary ☐ Cardiology Procedure ☐ Operative Report ☐ Discharge Summary

Billings Information: ☐ Standard **OR** ☐ Itemized Bill

☐ Other Records (please Specify):

INFORMATION TO BE USED FOR:

☐ Continuity of Medical Care ☐ Damage/Claim/Insurance Info ☐ Personal ☐ Attorney/Legal

☐ Workers Compensation/Disability ☐ Other (please specify):

Your are entitled to receive a copy of this Signed Authhorization.

CONTINUED ON NEXT PAGE →

AUTHORIZATION FOR THE USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

This authorization will expire on the following date, event, or condition:
If expiration date, event, or condition is not specified, this authorization will expire in 60 days. I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. **I have read the above and authorize the disclosure (release) of my medical or billing records as stated above.**

Signature of Patient/Patient Representative | Date

Printed Name of Patient/Patient Representative | Relationship to Patient

ADDITIONAL INFORMATION REGARDING YOUR REQUEST

I understand that this authorization is voluntary and that Vail Health will not base treatment, payment, enrollment, or eligibility for benefits on my signing of this document. Patient initials here:

Requesting medical records on behalf of another person: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir At Law, etc. Please contact **Medical Records at 970-569-7403** to determine the documentation that you will be required to process your request.

Requesting your records at the conclusion of your visit or while you are still a patient in the hospital: If you are requesting during your hospital stay or at the conclusion of your visit, please be aware that there may be outstanding reports/ documentation that may not be finalized at the time you receive the records you have requested. The records you receive should be considered incomplete and preliminary.

Turnaround time: Our average turnaround time for processing requests is 10 (ten) business days plus shipping time. However, it may require 30 or more days to complete your request. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your phone number on your request, in case we need to contact you for additional information. For questions regarding requests for medical record copies, please contact Vail Health at 970-569-7403.

Picking up your records: If you personally pick up your records or if you send a designee to pick up your records, a photo identification (driver's license, passport, etc.) will be **required** before the records are released.

Designee's Name as it appears on Driver's License:

ABSTRACT OF MEDICAL RECORDS INCLUDES:
Laboratory results, Imaging Reports, Imaging disc, History & Physical, Consultations, Discharge Summary, ED Physician note, Urgent Care Physician note, Cardiology Procedures, Operative Reports when applicable.

Vail Location
Vail Health: PO Box 40,000, Vail Co. 81658 181 W. Meadow Dr, Vail, Co. 81657,
Hours: 8 a.m.-4:30 p.m. • Tel.: (970) 477-3093 Fax: (970) 470-6600

Edwards Location
320 Beard Creek Road (rear of bldg), 2nd Fl., Edwards, Co. 81632
Hours: 8 a.m-4:30 p.m. • Tel: (970) 569-7403 Fax: (970) 470-6641 • Email: Medical.Records@VailHealth.org

FOR VAIL HEALTH USE ONLY:

Date Request Received:	Med. Rec. released by:	CD released by:	Completion Date:
Incomplete: ☐ Yes ☐ No	What was released:		Log Date:
MRN/FIN:	Number of Pages:	Number of Films:	

Your are entitled to receive a copy of this Signed Authhorization.