Colorado Mountain Medical
Doctors you know and trust.

Authorization to Release Patient Health Information

PATIENT NAME:_____ **DATE OF BIRTH:** _____

I authorize Colorado Mountain Medical to (check one or both) ❑release and/or ❑receive my PHI from the following:

Doctor/Hospital/Facility:
Address/City/State/Zip Code:
Phone No./ Fax Number:

SEND RECORDS VIA: ❑ USPS ❑ Unsecured Fax Line ❑Personal Pick up (❑Avon ❑Vail ❑Eagle ❑Dillon)
❑Verbal Authorization only ❑ Secured Email:_____

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 ❑ Operative Report ❑ Immunization Records
❑ Radiology/X-ray Reports ❑Urgent Care Record ❑ Laboratory Reports
❑Outpatient/Clinic Notes (specify physician/clinic):_____
❑ Other records (please specify): _____ ❑Billing Information: ❑ Standard **or** ❑ Itemized Bill

INFORMATION TO BE USED FOR: ❑ Continuity of Medical Care ❑ Damage/Claim/Insurance Information
❑ Personal ❑ Attorney/Legal ❑ Workers Compensation/Disability ❑ Other: _____

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 1 (one) year from the signed date.** 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**

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Additional Information Regarding Your Request
This authorization is voluntary and CMM will not base treatment, payment, enrollment, or eligibility for benefits on my signing of this document.
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 970-363-5434** 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 turnaround time for processing requests is 10 (ten) business days plus shipping time. 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 CMM at 970-363-5434.
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, History & Physical, Consultations, Outpatient/ Clinic Notes, Urgent Care Physician note, Operative Reports when applicable.

Medical Records:
50 Buck Creek Rd.
Suite 200
Avon CO, 81620
Monday-Friday 7:30 AM – 3:30 PM
Tel.: 970-363-5434 **Fax:** 970-926-6348 **Email**: CMM.HIM@vailhealth.org

You are entitled to receive a copy of this Signed Authorization