AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI)

Patient Information

Full Name: _____
Maiden or Other Names Used: _____
Address/City/State/Zip: _____
Date of Birth: _____ SS #: _____
Day Phone: _____ Alternate Phone: _____

(Circle One) Release TO / FROM

I authorize the following entity:

□ **Rangely District Hospital**, 225 Eagle Crest Dr., Rangely, CO 81648
(970) 675-4233; Fax (970) 675-4273.

□ **Rangely Family Medicine**, 225 Eagle Crest Dr., Rangely, CO 81648
(970) 675-2237; Fax (970) 675-2759

□ **Rangely Pharmacy**, 225 Eagle Crest Dr., Rangely, CO 81648
(970) 675-4200; Fax (970) 675-2160

Name: _____
Address: _____
_____
Phone #: _____ **Fax #:** _____

Attn: _____

Purpose

□ **Continuation of Care** □ **Insurance** □ **Legal** □ **Worker's Compensation**
□ **Personal** □ **Other (specify):** _____

PHI to be Disclosed

I authorize the following information to be released:
Dates of Service: _____

□ Discharge Summary □ Laboratory Reports □ Outpatient Procedures
□ Imaging □ History & Physical □ X-Ray Reports
□ Mammogram □ Clinic Records □ ER Report
□ Complete Record (all visits) □Other_____

Delivery Instructions

□ Mail records directly to person or organization specified. □ Flash Drive □ Disk □ Paper
□ Call me for pick up when records are ready.
□ I authorize_____ (designated representative) to pick up records for me.
□ Fax to above fax number. □ E-Mail encrypted *(more secure)* □ E-Mail unencrypted *(not recommended)*

Authorization (Initial Each Section)

- Without my express revocation, this authorization will automatically expire 6 months from the date signed below, unless I request an expiration date less than 6 months.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- I understand that information disclosed pursuant to the authorization by RHD, or records of other providers, on file, may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy rule.

I understand that the information to be released may include a diagnosis or reference to the following condition(s): **behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.**

To recipients of information related to drug and/or alcohol abuse: "This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR Part 2). The Federal rules prohibit you from making any (further disclosure of this information unless further disclosure is expressly permitted by the written consent of person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." (52 FR 21809, 1987; 52 FR 41997, Nov 2, 1987).

MINORS AGE 13-17: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minors' reproductive care including, but not limited to: contraception, pregnancy, and pregnancy termination, sterilization, and sexually transmitted diseases (age 14 and older), (2) alcohol and/or drug abuse (age 13 and older), and (3) mental health conditions (age 13 and older).

Signature

My signature is required to validate this authorization.
If I do not sign this authorization, Rangely Hospital District will still provide treatment and seek payment for services provided.

Signature of Patient/Guardian/Personal Representative: _____
Name: _____ **Relationship:** _____ **Date:** _____
If patient is unable to sign, document reason: _____

Rangely Hospital District Use Only
Medical Record #: _____
Date Authorization Received: _____
Authorization Received by: _____
Date Request Completed: _____
Request Completed by: _____
ID/DL # Verified: _____

Rev.5/2024 HIM

RANGELY FAMILY MEDICINE

RANGELY DISTRICT HOSPITAL
OUR MISSION IS YOUR HEALTH