MidValley Family Practice PC

1450 East Valley Road Suite 102, Basalt CO 81621
970-927-4666 Phone
970-927-6623 Fax

Authorization to Release Medical Records

Patient Name_____ **Date of Birth** _____

Please send my records ☐ **to MidValley Family Practice** ☐ **from MidValley Family Practice**

I Hereby Authorize

Name	Address	Phone	Fax
MidValley Family Practice	1450 E. Valley Rd #102 Basalt, CO 81621	970-927-4666	970-927-6623

And

Name	Address	Phone	Fax

To Share The Following Health Information

PLEASE INITIAL NEXT TO THE SPECIFIC TYPE OF HEALTH HISTORY:	**PRIVILEGED INFORMATION:**
_____ Only records generated by this facility _____ Lab Reports _____ Imaging Reports _____ All medical records at including records from other facilities _____ Specific Dates/Tests Only_____	*In compliance with Colorado statutes, which require special permission to release privileged information, please release the records only pertaining to the below as initialed:* _____ Mental health _____ Drug Abuse _____ HIV (AIDS) _____ Communicable Diseases _____ Alcoholism _____ Child Abuse _____ Sexually Transmitted Diseases _____ Cancer

Purpose for disclosure:

_____Transferring Care **_____Continuing Treatment and/or Consultation** **_____ To hold verbal discussion**

_____ Other _____

MY AUTHORIZATION IS GIVEN FREELY WITH THE UNDERSTANDING THAT:

1. Except as otherwise permitted or required a covered entity may use or disclose PHI that is valid. When a covered entity obtains/receives a valid authorization for its use or disclosure of protected health information (PHI), such use of discloser must be consistent with such authorize. 45 CFR (c) 2
2. I may revoke with authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing. MVFP will not change my treatment because of a signed release.
3. The authorization for release may include records which may include the presence of a communicable or non communicable disease. I understand that the records requested may be protected under 42 CFR Part 2 governing Alcohol and Drug Abuse patient records, the Health Insurance Portability Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 & 164, State Confidentiality laws and regulation and cannot be released without my consent unless otherwise provided for regulations. State and Federal Law regulations prohibit any further disclosure of such records without my specific written consent or when otherwise permitted by such regulations.
4. A photo copy or fax of this authorization is as valid as the original.
5. MFVP, its directors, officers, employees, agents, and volunteers are here by released from any legal responsibility of liability for disclosure of the above mentioned information to the extent indicated and authorized herein.
6. I am responsible for any fees associated with releasing my medical information.

Patient's Signature_____ **Date** _____

Person Authorized to sign for Patient Name/Relationship _____

Person Authorized to sign for Patient Signature_____

MVFP Office Use

_____date release sent

_____ date records sent

_____ date records received