TELLURIDE REGIONAL MEDICAL CENTER

Office Use TMC Staff Received Initals

RELEASE INFORMATION TO:

TELLURIDE REGIONAL MEDICAL CENTER
PO BOX 1229, 500 WEST PACIFIC AVENUE **Phone: 970-728-3848**
TELLURIDE, CO. 81435 **Fax: 970-728-3404**

Patient Information

Full Name _____ Date of Birth _____/_____/_____

Maiden or Other Names Used _____

Address _____
City State Zip

Day Phone # _____ Cell # _____

Release From

Person/Organization Name _____ / _____

Address _____
City State Zip

Phone # _____ Fax # _____ (please confirm correct fax# for provider)

Date(s) Of Information To Be Released/Accessed

Date(s) of Service from (mm/dd/year) _____/_____/_____ through (mm/dd/year) _____/_____/_____

Information To Be Disclosed

- ❑ Clinic Visit
- ❑ Laboratory
- ❑ Imaging Report
- ❑ EKG Report
- ❑ Emergency Report
- ❑ Laboratory

Mental Health (must check one box)
- ❑ YES
- ❑ NO

Substance Abuse (must check one box)
- ❑ YES
- ❑ NO

I Understand

I may ***revoke*** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Information disclosed pursuant to the authorization may be subject to ***re-disclosure*** by the recipient and is no longer protected by the HIPAA Privacy rule, unless the disclosure includes records to covered entities and federally assisted program specifically providing diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case ***re-disclosure*** **is prohibited** under 42 CFR Part 2.

My signature is required to validate this authorization. According to State Statutes, Telluride Regional Medical Center may charge for copies of medical records.

****** This Authorization expires on (mm/dd/year) _____/_____/_____**

/ /

Signature of Patient/Guardian/Personal Representative Relationship (if not the patient) Date

/ /

Personal Representative's **printed** Name Address Phone Number

If patient is unable to sign, document reason