Office Use TMC Staff Received Initials

Patient Account #

Patient Information

Full Name ____ Date of Birth ______/______/__________

Maiden or Other Names Used ______________________________________

Address ____
City State Zip

Day Phone # ______________________________ Cell # ______________________________

Release Information From

TELLURIDE REGIONAL MEDICAL CENTER
PO BOX 1229, 500 WEST PACIFIC AVENUE
TELLURIDE, CO. 81435

Phone: 970-728-3848
Fax: 970-728-3404

Release To

Person//Organization Name ______________________________ / ______________________________

Address ____
City State Zip

Phone confirmed # ______________________________ Fax confirmed #______________________________

Purpose

- ❑ Continuation of Care
- ❑ Insurance/WC
- ❑ Personal
- ❑ Legal
- ❑ Other (specify) ____

Date(s) Of Information To Be Released/Accessed

Date(s) of Service from (mm/dd/yr) ____/____/_______ through (mm/dd/yr) ____/____/______

Information To Be Released/Accessed

- ❑ Clinic Visit
- ❑ Laboratory
- ❑ Imaging Report
- ❑ EKG Report
- ☐ COVID Results
- ❑ Emergency Report
- ❑ Laboratory
- ☐ **Mental Health**
- ☐ **Substance Abuse**

Disclosure/Access Format

- ❑ Paper format – US Mail
- ❑ Paper format – Pick up
- ❑ CD
- ❑ Fax

Patient Access Format

- I will provide a picture ID prior to accessing my medical record.
- If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.

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