HIPAA Approved Contacts and Messages

Patient's Name: _____ Date of Birth: ____ / ____ / ____

Release of Information

I authorize the release of my medical information and records (including but not limited to information about my appointments, diagnoses, treatment, results, and billing information) to the following people:

Name	Phone Number	Relationship

My medical information and records should NOT be released to:

Name	Phone Number	Relationship

Messages

If TRMC staff are unable to reach me by phone:

[ ] they may leave a detailed message (including but not limited to information about my appointments, diagnoses, treatment, results, and billing information) on this/these phone number(s):

_____

[ ] they should leave a non-detailed message asking for me to return the call

This Medical Information Release Form will remain in effect until I provide an updated form or a written request to make changes.

Patient/Legal Guardian Signature: _____ Date: ____ / ____ / ____

TELLURIDE REGIONAL MEDICAL CENTER

Request for ADULT (Age 18+) Proxy Access

Patient Information

Full Name_____Date of Birth _____

Email Address_____ Social Security Number: XXX-XX-_____(last 4 digits)

Address _____

City State Zip

Day Phone #_____Cell # _____

Proxy Information

Full Name_____ Date of Birth _____

Email Address_____ Social Security Number: XXX-XX-_____(last 4 digits)

Relationship to Patient_____ I have my own personal TRMC Patient Portal account: ☐ Yes ☐ No

Address _____

City State Zip

Day Phone #_____Cell # _____

Acknowledgement

- I understand by submitting this form, I have requested the person indicated above to act on my behalf (a "proxy") to obtain information regarding my health included in my electronic health record.
- This authorization is voluntary, and the disclosure is made at my request.
- I understand that I need not sign this form to ensure health care treatment at Telluride Regional Medical Center (TRMC).
- I understand that my medical information is confidential. It is securely maintained in an electronic system by TRMC.
- I understand that failure to comply with the TRMC Patient Portal User Agreement may result in the termination of portal access privileges.
- I understand that my TRMC Patient Portal **may** include a diagnosis or reference to the following condition(s): *behavioral health services/psychiatric care; reproductive health; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.*
- I understand that information accessed may be subject to redisclosure by the Proxy and is no longer protected by the HIPAA Privacy rule.
- I understand that if access to my TRMC Patient Portal is granted, access will remain in effect until revoked in writing.
- I understand that if access to my TRMC Patient Portal is revoked, the information previously viewed by the above-named person(s) would not be considered a breach of confidentiality.
- TRMC reserves the right to revoke access to the TRMC Patient Portal at any time for any reason.
- I acknowledge that I have read and understand this ADULT (Age 18+) Proxy Access form and that the full Terms and Conditions of the TRMC Patient Portal are available to me online. I agree to its terms and choose to designate the person named above as my Patient Portal Proxy, thereby allowing them access to my TRMC Patient Portal account.

A signature is required to validate this request. By signing this form, the signer is requesting that the person(s) named above be granted access to electronically view the patient's medical record via the TRMC Patient Portal.

_____

Signature and PRINTED Name of Patient/Legal Representative (include relationship) Date

BRING PAPERWORK AND A FORM OF IDENTIFICATION IN PERSON TO:

Telluride Regional Medical Center
500 West Pacific Ave Telluride, CO

Office Use Only:

Pt Photo ID verified:_____
Date received: _____
Date completed: _____