THE STEADMAN CLINIC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Location: 181 West Meadow Drive, Ste 400, Vail, Colorado 81657 | T 970.476.1100 | F 970.479.5835
Email: medicalrecords@thesteadmanclinic.com | **Hours of Operation:** 8 a.m. - 5 p.m. Monday - Friday

Patient Information:

Patient Name: _____ Date of Birth: _____/_____/_____

Phone: (_____) _____ Alias: _____ Email: _____

I direct and hereby authorize The Steadman Clinic to deliver or communicate the Protected Health Information specified in this authorization to myself and the party or parties specified in the following medium:

☐ Landline ☐ Message on Voicemail ☐ Cell Phone ☐ Message on Voicemail ☐ Text Message ☐ E-mail ☐ Fax ☐ Mail

I request my protected health information (PHI) to be used or disclosed to the following person, class of persons, or organization:

☐release of medical records ☐ verbal discussion ☐ no records sent at this time please keep

Name: _____

Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Email: _____

I request my protected health information (PHI) to be released from my medical record(s): (Please check all that apply or describe the information specifically).

☐ Discharge Summary ☐ Discharge Instructions ☐ History and Physical ☐ ER Record ☐ Medication Records ☐ Lab Report ☐ Treatment Plan ☐ Clinic Note ☐ Consultation ☐ Operative Report ☐ Pre-Operative ☐ Notes EKG / ECG

☐ Provider's Name: _____
☐ Other: _____
☐ Specific Date(s): _____ to _____ **or if no dates are specified, the last two (2) years will be released.**

I authorize the release of information in my health record which may include information related to:

☐ Behavioral or Mental Health Issues ☐ Sexually Transmitted Diseases ☐ Sexual Assault Nurse Examiner Reports
☐ Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus
☐ (HIV) Alcohol and Drug Treatment

Purpose for requesting information: (Please check one)

☐ Request of Patient ☐ Continuation of Care ☐ Other: _____

By signing this authorization, I understand that:

- The authorization form is in effect until revoked by me, or until any records retention period applicable to my records has expired, whichever is sooner.
- Electronic media and delivery methods such as e-mail, or text messages, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of TSC/SPRI. I agree to assume such risks personally, and to hold TSC/SPRI harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing TSC/SPRI to transmit or deliver such information electronically.
- My refusal to sign this form will not adversely affect my ability to receive health services, reimbursement for services and an enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above indicated recipient without my signature. I acknowledge the information disclosed pursuant to this authorization may be subject to re-discloser by the recipient and no longer protected by Federal Law.
- I have the right to revoke this authorization by written notice to TSC/SPRI. I understand actions taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.
- There may be costs associated with this request in compliance with State copying laws.

Patient/Authorized Representative* Signature:_____ Date:_____

Printed Name of Authorized Representative:_____ Relationship to Patient:_____

* If signed by a patient's authorized representative, supporting legal documentation must accompany this authorization form.

Nondiscrimination

The Steadman Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

This information available in Spanish upon request. Solicite la versión en español de esta información.