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:** M-F 8 a.m. - 5 p.m.

Patient Name: _____ Date of Birth: _____

Patient Address, City, State, Zipcode: _____

I direct and hereby authorize The Steadman Clinic (TSC) to deliver or communicate the protected health information (PHI) specified in this authorization to myself and the party or parties specified in the following medium:

☐ E-mail ☐ Fax ☐ Mail

I request my PHI to be used or disclosed to the following person, class of persons, or organization:

Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

Name: _____

Address: _____ City/State/Zip: _____

Phone: _____ Email: _____

Purpose:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other _____

I request my PHI to be released from my medical records(s): (Please check all that apply or describe the information)

☐ All ☐ Clinic Summary/Consultation ☐ Procedure ☐ Laboratory/Radiology ☐ Other _____

For Treatment Date(s): _____ to _____ **or if no dates are specified, the last two (2) years will be released.**

___ By **initialing**, I authorize the release of my health records that may include information indicating the presence of communicable or venereal diseases, which may include, but are not limited to: hepatitis, syphilis, gonorrhea, the Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

___ By **initialing**, I authorize the release of my health records that may include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.

By signging 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 pose certain risks to the privacy and security of my PHI that may be beyond the control of TSC. I agree to assume such risks personally, and hold TSC harmless in the event my PHI is breached or compromised as a result of my directing and authorizing TSC to transmit or deliver such information electronically.
- I have the right to revoke this authorization by written notice to TSC. 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.
- If I sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

_____

Patient or Authorized Representative Signature Date Relationship