THE STEADMAN CLINIC
STEADMAN PHILIPPON
RESEARCH INSTITUTE

The Steadman Clinic
181 West Meadow Drive STE 400
Vail Colorado 81657
T 970.476.1100 F 970.479.5835

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Please sign this form in the event that you need your records in the future. This release will be placed in your chart. If you need a copy of your records, you MUST contact our Medical Records Department at 970-476-1100.

I hereby authorize The Steadman Clinic to release medical information from the records of:

Patient Name: ______________________ Date of Birth: ________________ Phone#: ________________

Patient Mailing Address: ____

City: __________________________ State: ________ Zip Code: ________________

Date(s) of Treatment Requested: ____

Information to be disclosed (check all applicable items to be released): 9Y l·łf !ŘŘŊŜăăΥψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψψ

- ☐ Discharge Summary
- ☐ ER Record
- ☐ Treatment Plan
- ☐ Operative Report
- ☐ Discharge Instructions
- ☐ Medication Records
- ☐ Clinic Note
- ☐ Pre-Operative Notes
- ☐ History and Physical
- ☐ Lab Report
- ☐ Consultations
- ☐ EKG / ECG
- ☐ Other (specify): ____

The Information May Be Disclosed To The Following:
Recipients Name: ____

Street Address: ____

City: __________________________ State: ________ Zip Code: ________________

Telephone #: __________________________ Fax #: __________________________

Delivery : ☐ I will pick-up my records ☐ Please mail records to the above address ____________________

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 the Healthcare Provider listed above. I understand actions taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.
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.

I understand the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree there may be costs associated with this request in compliance with State copying laws.

______________________________________ ______________________________
Signature of Patient or Personal Representative* Date of Signature

*If signed by personal representative, a description of the representative's authority to act is as follows:

☐Parent Legal ☐Guardian ☐Healthcare Power of Attorney ☐Administrator ☐Executor of Estate ☐Next of Kin ☐Beneficiary