VAIL HEALTH

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: Date of Birth:

Name at Time of Treatment (if different than above):

Mailing Address:

City: State: Zip Code:

Email: Phone:

I REQUEST MEDICAL RECORDS FROM:

☐ Vail Health Hospital (ER, Urgent Care Radiology, etc.) ☐ Vail Health Cardiology ☐ Shaw Cancer Center

☐ Howard Head Sports Medicine ☐ Sonnenalp Breast Center ☐ Precourt Healing Center

☐ Other Provider / Facility:

Address:

City: State: Zip Code:

Phone: Fax: Email:

I REQUEST MY RECORDS BE RELEASED BY THE FOLLOWING METHOD:

Send my records via: ☐ Mail (listed above) ☐ Email* (listed above) ☐ Fax* ☐ Edwards Pick Up ☐ Vail Pick Up

* I understand that there is a risk to me when my information is transmitted via an unsecured email or fax, and the information could be accessed by a third party during the transmission process. By checking the box to request electronic delivery I accept this risk

Sensitive Data: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.

☐ I Authorize Release; ☐ I Do Not Authorize Release; ☐ This is not applicable to me.

I REQUEST MY RECORDS BE SENT TO:

☐ Self (patient only)

☐ Other: Name of Fascility or Person

Address:

City: State: Zip Code:

Phone: Fax: Email:

INFORMATION TO BE RELEASED:

From Dates of Service (Month /Day/Year): to

☐ Abstract (See Back of Form) ☐ Cardiology Procedure ☐ Chemotherapy/Radiation ☐ Discharge Summary

☐ Emergency Room ☐ History/Physical (Medical History) ☐ Immunization Records ☐ Labor and Delivery Summary

☐ Lab Results/Pathology ☐ Physical/Speech/Occupational Therapy ☐ Operative/Procedure Report

☐ Radiology Reports ☐ Radiology Images (Digital)

☐ Billing Information:

☐ Outpatient/Clinic Notes (Specify Physician/Clinic):

☐ Other Records (Please Specify):

INFORMATION TO BE USED FOR:

☐ Continuity of Medical Care ☐ Insurance Information ☐ Personal ☐ Attorney/Legal

☐ Workers Compensation/Disability ☐ Other:

You are entitled to receive a copy of this Signed Authorization

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VAIL HEALTH

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

AUTHORIZATION FOR THE USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

This authorization will expire on the following date, event, or condition: _____

If expiration date, event, or condition is not specified, **this authorization will expire in 60 days**. I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. **I have read the above and authorize the disclosure (release) of my medical or billing records as stated above.**

Signature of Patient/Patient Representative _____ Date _____

Printed Name of Patient/Patient Representative _____ Relationship to Patient _____

ADDITIONAL INFORMATION REGARDING YOUR REQUEST:

☐ **I understand that this authorization is voluntary and that Vail Health will not base treatment, payment, enrollment, or eligibility for benefits on my signing of this document.** Patient initials here: _____

Requesting medical records on behalf of another person: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir At Law, etc. Please contact **Medical Records at 970-569-7403** to determine the documentation that you will be required to process your request.

Requesting your records at the conclusion of your visit or while you are still a patient in the hospital: If you are requesting during your hospital stay or at the conclusion of your visit, please be aware that there may be outstanding reports/documentation that may not be finalized at the time you receive the records you have requested. The records you receive should be considered incomplete and preliminary.

Turnaround time: Our average turnaround time for processing requests is 10 (ten) business days plus shipping time. However, it may require 30 or more days to complete your request. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your phone number on your request, in case we need to contact you for additional information. For questions regarding requests for medical record copies, please contact **Vail Health at 970-569-7403**.

Picking up your records: If you personally pick up your records or if you send a designee to pick up your records, a photo identification (driver's license, passport, etc.) will be required before the records are released.

Designee's Name as it appears on Driver's License: _____

Abstract of Medical Records includes: Laboratory results, Imaging Reports, History & Physical, Consultations, Discharge Summary, ED Physician note, Cardiology Procedures, Operative Reports when applicable.

VAIL

Vail Health Hospital
180 South Frontage Road West, Vail, CO 81657
Phone: (970) 569-7403 Fax: (970) 470-6641
Monday – Friday: 8AM – 4PM

EDWARDS

Edwards Pavilion
320 Beard Creek Road, Edwards, CO 81632
Phone: (970) 569-7403 Fax: (970) 470-6641
Monday – Friday: 8AM – 4PM

Email **Medical.Records@VailHealth.org** or visit **VailHealth.org/MedicalRecords** for more information.

FOR VAIL HEALTH USE ONLY			
Date Request Recvd:	Med. Rec. released by:	CD released by:	Completion Date:
Incomplete: ☐ Yes ☐ No	What was released:		Log date:
MRN/ FIN:		# of pages:	# of films:

You are entitled to receive a copy of this Signed Authorization