WRAY COMMUNITY DISTRICT HOSPITAL & CLINIC

Phone 970.332.4811 & 970.332.4895 Fax 970.332.4017 & 970.332.4665

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Wray Community District Hospital & Clinic to disclose the following information from the health record of:

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ MR# _____

Address _____ Phone Number _____

City _____ State _____ Zip _____ Fax Number _____

Electronic Request: ☐ E-mail ☐ CD **Paper** Request: ☐

Email Address for record delivery

INFORMATION REQUESTED

Service Dates

From: _____

To: _____

- ☐ All Pertinent Records (includes those listed below)
  - ☐ Allergies
  - ☐ Consultation
  - ☐ Discharge Summary
  - ☐ Dr Orders
  - ☐ Echo Reports
  - ☐ ER Report
  - ☐ EKG Report
  - ☐ History & Physical
  - ☐ Laboratory
  - ☐ Medication List
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Physician Progress Notes
- ☐ Radiology Reports
- ☐ Radiology Image (s)_____
- ☐ Psychiatric Care Record/Behavioral Health
- ☐ Screening and/or Treatment of Alcohol and/ or Substance Abuse
- ☐ Entire Official Patient Medical Record
- ☐ Specify:_____
- ☐ Billing Record
- ☐ Clinic Notes

PURPOSE OF DISCLOSURE

☐ Further Medical Care ☐ Patient's Request ☐ Application for Insurance ☐ Social Security Disability ☐ Legal Investigation or Action ☐ Other

INFORMATION to be VIEWED BY or GIVEN TO

Company, Person, Facility _____ Phone Number/Fax Number _____

Address _____ City _____ State _____ Zip Code _____

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/ Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; I authorize the release of any such information.

I may refuse to sign this authorization form. I understand that Wray Community District Hospital will not condition or deny treatment on my signing this authorization.

I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Wray Communtiy District Hospital Notice of Privacy Practice explains the process for revocation, which includes a request in writing.

Unless I revoke this authorization earlier, it will expire 6 months from the date signed or as specified: _____.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations, and may be re-disclosed by the person or organization that receives the information.

I release Wray Communtiy District Hospital, its employees and agents, medical staff, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient _____ Date _____

In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicating health care decisions.

Signature of Legal Representative _____ Relationship to Patient or Description of Authority to Act for Patient _____

For Healthcare Use Only

Employee completed/reviewed form with patient:_____ **ID verified:**_____

Date Received:_____ **Date Sent:**_____ **Processor :**_____

Records Picked Up By:_____Date:_____