Wray Hospital & Clinic
1017 W 7th Street Wray, CO 80758
Medical Records Phone 970.332.2214 Medical Records Fax 970.332.4017
wcdhmedicalrecords@bannerhealth.com

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize Wray Community District Hospital & Clinic (WCDH) to disclose the following medical information:

Please complete in blue or black ink **Request will be processed within 10 business days**

PATIENT INFORMATION

Legal Last Name _____ First Name _____ Date of Birth _____ Medical Record # _____

Address _____ Phone Number _____

City _____ State _____ Zip _____ Fax Number _____

Electronic Request: ☐ E-mail ☐ CD Paper Request: ☐ Mail ☐ Pick-up

Email Address: _____

INFORMATION REQUESTED

Dates of Service

From: _____

To: _____

- ☐ Allergies
- ☐ Behavioral Health/Psychiatric Records
- ☐ Billing Records
- ☐ Clinic Notes
- ☐ Consultation
- ☐ Discharge Summary
- ☐ Dr Orders
- ☐ Echocardiogram Reports
- ☐ EKG Report
- ☐ Emergency Dept Report
- ☐ Entire Medical Records
- ☐ History & Physical
- ☐ Laboratory Test Results
- ☐ Medication List
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Physician Progress Notes
- ☐ Radiology Images & Report
- ☐ Radiology Images Only
- ☐ Radiology Report Only
- ☐ Substance Abuse Treatment
- ☐ Vaccination Records
- ☐ Other (specify) _____

PURPOSE OF DISCLOSURE

- ☐ Continuing Medical Care
- ☐ Personal Use
- ☐ Application for Insurance
- ☐ Social Security Disability
- ☐ Legal Investigation
- ☐ Other

RELEASE 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/Psychiatric Care, alcohol and/or drug abuse treatment, genetic testing; I authorize the release of any such information.

*I understand that I may refuse to sign this authorization form. WCDH will not condition or deny treatment based on 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. The WCDH Notice of Privacy Practice explains the process for revocation, which must be 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 WCHD, 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

_____ _____
Signature of Legal Representative Date Relationship to Patient/Authority

As the designated agent, in signing above, I attest to the continuing inability of the above patient to make or communicate health care decisions.

For Internal Use Only

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

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

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