Authorization to Release Medical Records

Patient is requesting Canyonlands Healthcare to: □**obtain** □**send**

Organization Who Is Releasing Information
Facility:
Address:
City, State, Zip:
Fax: Phone:

To Whom Information Will Be Provided
Entity/Individual:
Address:
City, State, Zip:
Fax: Phone:

Patient Information:	Patient Name: _____ Date of Birth: _____ Address: _____ Phone Number: _____ _____
Dates Requested:	□ Treatment dates from ___/___/_____to ___/___/_____ □ All treatment dates

There may be a FEE associated with your Request for Records

Records Being Requested:	□ Complete medical record □ Clinical notes □ Immunization records □ Laboratory results □ My health information relating to the following treatment or condition: _____ _____	□ Billing/financial records □ Scheduling information/appointments □Prescription/Pharmacy Records □Dental Records *Please note that Canyonlands Healthcare may only send medical records from another healthcare facility as permissible by the Privacy Rule.
I understand that information to be released may include reference to sensitive information related to mental and behavioral health, HIV/AIDS or other communicable diseases, and drug or alcohol use.		
Delivery Of Records:	□ Mail □Pick Up (in-clinic, ID required) □Fax	
Purpose:	□Self □Continuing Care □Other _____	
This authorization will expire:	□ On this date ___/___/_____ □ Never, unless I cancel in writing	□ Once the information is received □ Other _____

Additional People Who May Discuss My Medical Information:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

Under Federal privacy laws, Canyonlands Healthcare ("CHC") is authorized to use or disclose your health information for treatment, payment and health care operations and as required by law. For uses and disclosures other than these purposes, your written authorization is required before sharing your health information. It is the policy of CHC not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent or legal guardian of a minor child or incapacitated adult, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This includes sharing your health information with your spouse, relatives, friends, etc. This form allows you to authorize CHC to use or disclose your health information to those individuals you specify.

- I authorize CHC to release health information as indicated above.
- I understand that I have a right to receive a copy of this authorization after I have signed it and inspect or copy health information I have authorized to be used or disclosed by this authorization.
- I understand that under Federal Law, CHC has 30 days from the date of this request to deliver my health record.
- I understand that information disclosed to a third party may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
- I understand that I may revoke this authorization at any time in writing and provided to my CHC healthcare provider or the CHC Privacy Officer, P.O. Box 1625, Page, AZ 86040. My revocation notice will not apply to actions taken by CHC in reliance upon this authorization prior to the date CHC receives my written request to revoke this authorization.
- I have had the opportunity to review and understand the contents of this authorization.
- CHC will not share or use my health information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law. CHC's Notice of Privacy Practices is available upon request.
- I release CHC, its employees, agents, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
- By signing this authorization, I am confirming it accurately reflects my wishes.

Signature of Patient _____ Date _____

Signature of Legal Representative _____ Date _____

Relationship to Patient _____

CHC Representative Name (PRINT) _____ Date _____

FOR CHC INTERNAL USE ONLY			
HIPAA Link	PHI Log (released)	Records Released by CHC	Submit to Verisma for □Release of Records □Scan to chart only
Date Entered: Initials:	Date Completed: Initials:	Date : Initials:	Date: Initials:

Name: _____

DOB: _____