



Authorization for Disclosure of Patient Health Information

Eff. 10/2006

Rev. 01/2019

Release of Information May be Incomplete if Medical Record is Released Within 30 Days of Patient Encounter

PATIENT NAME:	SOCIAL SECURITY NUMBER:	DATE OF BIRTH:
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Animas Surgical Hospital Medical Records Phone 970-385-2395 Fax: 970-385-2389

Email Address: mr@animasurgical.com

I authorize Animas Surgical Hospital the use or disclosure of my protected health information as described below. Animas Surgical Hospital is authorized to make disclosures to: Patient Other, individual or organization

Name:
Address:
City/State:
Phone Number: _____ Fax Number: _____

PURPOSE OF THE RELEASE: Continuity of Care Legal Personal Other: _____

Date of Service(s) _____ to _____

The extent or nature of information to be released:

- Face Sheet
- Emergency Room Record
- Lab Results
- Imaging Reports
- Operative Report
- Pathology Report
- Entire Record
- EKG
- Other, please specify _____

Imaging PowerShare Enrollment **Email:** _____

PATIENT ONLY:

I request a copy of an accounting of the uses and disclosures of protected health information. The first accounting within a twelve (12) month period is free of charge, any additional request will be charged as listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Services. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire ninety (90) days from the date of signing below.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in section CFR 164.524 of the Health Insurance Portability and Accountability Act. I understand that if the person or entity authorized to receive the information is not a healthcare provider or health plan the released information may no longer be protected by federal privacy regulations. If I have questions about disclosure of my health information, I can contact the Health Information Management Services

Signature of Patient or Legal Representative Date

If signed by Legal Representative, Relationship to Patient Date

_____ Date information released _____ Enrollment Date
 _____ Initials of individual making disclosure _____ Initials of staff completing PowerShare enrollment