SMG Specialty Care, SMG Women's and Family Health, SMG Primary Care, SMG Mancos Valley, SMG Walk-In Care, SMG School-Based Health Center

REQUEST FOR INFORMATION RELEASE FORM

I hereby authorize the release of medical record information of ______________________________
Patient's Name (print)

From: Physician/Facility/Other:______________________________ **Copy Requested**: ❑ Yes ❑ No
Address:______________________________ **Copy Received**: ❑ Yes ❑ No
City/State/Zip:______________________________
Phone:____________________ Fax:____________________

To:
- ❑ SMG Mancos Valley, 111 E Railroad Ave, Mancos, CO 81328, Phone (970) 533-9125, Fax (970) 533-7310
- ❑ SW Walk-In Care, 1413 N. Mildred Rd., Cortez, CO 81321, Phone (970) 564-1037, Fax (970) 564-1041
- ❑ SW School-Based Health Center,418 S. Sligo Street, Cortez, CO 81321, Phone (970) 564-4855, Fax (970) 565-5455
- ❑ SMG Specialty Care, 1311-A N. Mildred Rd., Suite A, Cortez, CO 81321, Phone (970) 564-2681, Fax (970) 564-2682
- ❑ SMG Women's and Family Health, 1311-A N. Mildred Rd., Suite B, Cortez, CO 81321, Phone (970) 564-2662, Fax (970) 564-2658
- ❑ SMG Primary Care: Family Medicine, 1311-A N. Mildred Rd., Suite C, Cortez, CO 81321, Phone (970) 565-8556, Fax (970) 564-1134
- ❑ SMG Primary Care: Sleep and Pulmonary Medicine, 1311-A N. Mildred Rd., Suite C, Cortez, CO 81321, Phone (970) 564-2678, Fax (970) 565-2487
- ❑ SMG Primary Care, 1311-A N. Mildred Rd., Suite D, Cortez, CO 81321, Phone (970) 565-8556, Fax (970) 564-1134
- ❑ San Juan Regional Heart Center, 20 S. Market Suite #3, Cortez, CO 81321, Phone (970) 565-0712, Fax (970) 565-0732
- ❑ Interventional Spine Care, 20 S. Market Suite #4, Cortez, CO 81321, Phone (970) 565-0712, Fax (970) 565-0732
- ❑ San Juan Health Partners Urology, 20 S. Market Suite #4, Cortez, CO 81321, Phone (970) 565-0712, Fax (970) 565-0732

Identifying Information:
Patient's Name at Time of Treatment: ______________________________
PRINT NAME
Provider: ______________________________
Date of Birth:____________________Date(s) of Treatment: ____________________
Reason for Release:______________________________
Format in which you wish to receive information: ❑ Encrypted Email Email address:____________________
❑ USB ❑ CD ROM ❑ Fax ❑ Other:____________________

Information Requested: I authorize the use or disclosure of the following protected health information:

- ❑ All Treatment Records (**Excluding Behavioral Health**)
- ❑ Behavioral Health Records
- ❑ ER Records
- ❑ History and Physical
- ❑ Imaging Reports
- ❑ Discharge Summary
- ❑ Consultation
- ❑ EKG, EEG
- ❑ Lab Reports
- ❑ Other: ____________________

Sensitive Information: I understand that the information in my record may include information related to sexually transmitted diseases, AIDS, or HIV infection. I may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I may revoke this authorization at any time by notifying Southwest Health System, Inc. ***in writing***. I understand that revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition: If not specified, this authorization will expire in 6 months.

Re-Disclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law also known as HIPAA and the recipient of your health information may potentially re-disclose it. However, under Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

This Authorization is Binding: The statements made in this authorization are binding, controlling and I understand that they take precedence over statements made in Southwest Health System, Inc.'s Notice of Privacy Practices.

By signing this Authorization Form, I understand I am giving my authorization to Southwest Health System, Inc. to use and/or disclose my protected health information (PHI), as described in more detail above to the entity/individual specified above.

I understand that I am not required to sign this form in order to receive treatment.

Signed (signature required):

Patient, Parent or Legal Guardian:______________________________Date: ____________________
Printed Name of patient's personal representative if applicable:______________________________
Relationship to patient if applicable:____________________Verified by: ____________________