MEDICAL RECORDS DEPARTMENT
1000 W. 8th Ave, Yuma CO 80759
PHONE 970-848-4622 FAX 970-848-2379

YUMA Hospital & Clinics

Authorization to Release Medical Information

(The execution of this form does not authorize the release of informtion other than that specifically described below.)

Please Request Records From: Print name and address of doctor, agency or health care facility.

_____

_____

_____

Patient: Print Name _____ DOB _____ SSN# _____ Phone _____

Release To: Name and address of organization, agency or individual to whom information is to be released.

_____

Address _____

_____

I hereby request and authorize the above-named doctor or health care provider to release copies of the information specified below to the organization, agency or individual named on this request. I understand that the information to be released may include information regarding the following condition(s):

( ) Drug Abuse ( ) Alcoholism or Alcohol Abuse ( ) Sickle Cell Anemia/HIV/AIDS ( ) Psychological or Psychiatric Conditions

Information Requested:

( ) All medical information requested.
( ) Copy of history and physical discharge summary and operative reports
( ) Copy of complete hospital chart
( ) Other (listed here)

Dates Covered: ( ) All admissions or care by this facility or doctor. ( ) Limited to treatment dates or conditions described here:

_____

_____

Purpose(s) or need for which information is to be used: ( ) Claims ( ) Insurance ( ) Lawsuit ( ) Attorney Request ( ) Workman's Compensation ( ) Other (listed here)_____

This information will be utilized only for the above purpose in connection with patient claims against _____ _____ (and others).

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that the action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without further written consent. Without my express revocation, this consent will automatically expire: ( ) upon satisfaction of the need for disclosure; ( ) on _____ (date supplied by patient); ( ) Until revoked in writing by patient; ( ) 180 days from the date hereof; ( ) under the following conditions:

_____

Other Conditions: A copy of this authorization or my signature thereon ( ) may ( ) may not be utilized with the same effectiveness as an original.

_____	_____	_____
Date	**Signature of Patient/Guardian/Power of Attorney**	**Person Authorized to Sign for Patient**
_____	_____	_____
Date	**YDH Representative / Witness**	**Printed Name of Witness**