Spanish Peaks Family Clinic / Spanish Peaks Family Clinic La Veta
Spanish Peaks Outreach and Women's Clinic / Spanish Peaks Specialty Clinic

RELEASE OF PATIENT INFORMATION

Released from: Spanish Peaks Family Clinic ____
Spanish Peaks Family Clinic La Veta ____
Spanish Peaks Women's Clinic ____
Spanish Peaks Specialty Clinic ____

Released to: ☐ Patient
☐ Other Person/ Relationship:______________________________
☐ Other Facility

Patient Name ______________________________
Mailing Address ______________________________
City State Zip ______________________________
Phone Fax ______________________________
Patient's Date of Birth: __________________________
Email Address: __________________________________
☐ New ☐ Updated

Other Person or Other Facility Name ______________________________
Mailing Address ______________________________
City State Zip ______________________________
Phone Fax ______________________________

Patient: ☐ Pick Up ☐ Fax ☐ Mail
Other Person: ☐ Pick Up ☐ Fax ☐ Mail
Facility: ☐ Fax ☐ Mail

INFORMATION TO BE COPIED AND RELEASED (CHECK ALL THAT APPLY):

Date(s) of service: ____

☐ Medical office/Clinical records
☐ Lab/Pathology Results
☐ Radiology Reports
☐ Radiology Images
☐ All records for specified physician or facility/clinic: ______________________________
☐ Records limited to a specific provider/department:______________________________
☐ Billing/Claims Information
☐ Other (specify): ______________________________

I DO ☐ or **I DO NOT** ☐ consent to release of information relating to psychiatric or psychological testing or treatment, alcohol, and/or drug abuse diagnosis, prognosis and treatment, and /or HIV(AIDS) testing and/or results, genetic testing/results, sickle cell anemia testing/results. *****NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. *****

THE PURPOSE FOR THIS RELEASE:
☐ Continuity of Medical Care ☐ Damage/Claim Information ☐ Personal Use ☐ Legal
☐ Other: ____

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge incomplete forms cannot be processed and there may be a cost to copy these records.

I understand **this consent expires one year from the date of my signature** unless otherwise specified as follows:___________________________. I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original. **Please retain a copy of your records for your personal use.**

~~~~~~PLEASE ALLOW 10 BUSINESS DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED~~~~~~

Signature of Patient/Representative ____________ **Date/Time** ____________ **Signature of Witness** ____________ **Date/Time** ____________

Name of SPRHC Staff person who released medical records:______________________________**Date:** ____________

OFFICE USE ONLY: Proof of Identification: ______________________________
Number of pages released:______________________ Completion date: __________________ Delivery method: ______________________
Name of individual who received request:______________________________Date received:______________________
Patient Medical Record Number / Account Number:______________________________ REV/AUG 2017