Spanish Peaks Veterans Community Living Center

23500 U.S. Highway 160
Walsenburg, CO 81089
Telephone 719-738-5205
Fax 719-738-5760

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Released from: **Spanish Peaks Veterans Community Living Center**

Released to: ☐ Patient/Resident ☐ Other Person/ Relationship:_____ ☐ Other Facility

Resident Name

Mailing Address

City State Zip

Phone Fax

Other Person or Other Facility Name

Mailing Address

City State Zip

Phone Fax

Resident's Date of Birth: _____

Email Address: _____

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

☐ New ☐ Updated

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

Date(s) of service: _____

- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Physician Progress Notes
- ☐ Nurses Notes
- ☐ Social Services Notes
- ☐ Care Plan
- ☐ Medication Records
- ☐ Physician Orders
- ☐ Lab/Pathology Reports
- ☐ Diagnostic Reports
- ☐ Billing Records
- ☐ 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 SPVCLC 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/2018