VAIL VALLEY SURGERY CENTER

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

MEDICAL AND BILLING RECORDS

PATIENT INFORMATION:

Patient Name	Date of Birth

RELEASE MEDICAL RECORDS FROM:	**SEND MEDICAL RECORDS TO:**
Doctor/Hospital/Facility	Doctor/Hospital/Agency/Facility/Person
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code
Phone No. (Identify country)/Fax Number	Phone No. (Identify country)/Fax Number/Email

SEND MY RECORDS VIA:

☐ USPS Mail ☐ Secured Email ☐ Unsecured Fax Line
☐ Edwards pick up ☐ Vail pick up ☐ Verbal Authorization only

SENSITIVE DATA: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.

☐ I Authorize Release ☐ I Do Not Authorize Release ☐ This is not applicable to me

INFORMATION TO BE RELEASED:

From Dates of Service (Month /Day/Year): _____/_____/_____ to _____/_____/_____

☐ Anesthesia Records ☐ History Physical/Consult ☐ Entire Record Including Billing
☐ Discharge Summary ☐ Labs/Pathology Reports ☐ Entire Record Excluding Billing
☐ EKG/Cardiopulmonary Reports ☐ Operative Report ☐ Other Records (please specify):
☐ Billing Information: ☐ Standard **or** ☐ Itemized Bill _____

INFORMATION TO BE USED FOR:

☐ Continuity of Medical Care ☐ Damage/Claim/Insurance ☐ Legal
☐ Personal ☐ Workers Compensation/Disability ☐ Other (please specify):
_____

Authorization for the use of Disclosure of Protected Health Information:

This authorization will expire in 180 days. I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. **I have read the above and authorize the disclosure (release) of my medical and/or billing records as stated above. I understand that this authorization is voluntary and that Vail Valley Surgery Center will not base treatment, payment, enrollment, or eligibility for benefits on my signing of this document.**

_____ _____
Signature of Patient/Patient Representative **Date**

_____ _____
Printed Name of Patient/Patient Representative **Relationship to Patient**

You are entitled to receive a copy of this Signed Authorization

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Additional Information Regarding Your Request
Requesting medical records on behalf of another person: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir at Law, etc. Please contact **Medical Records at 970-569-7707** to determine the documentation that you will be required to process your request.
Requesting your records at the conclusion of your visit at VVSC: If you are requesting at the conclusion of your visit, please be aware that there may be outstanding reports/documentation that may not be finalized at the time you receive the records you have requested. The records you receive should be considered incomplete and preliminary.
Turnaround time: Our average turnaround time for processing requests is 5 (five) business days plus shipping time. However, it may require 30 or more days to complete your request. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your phone number on your request in case we need to contact you for additional information. For questions regarding requests for medical record copies, please contact Vail Valley Surgery Center at 970-569-7707 or vvscmedrec@vailhealth.org.
Picking up your records: If you personally pick up your records or if you send a designee to pick up your records, **a photo identification (**driver's license, passport, etc.) will be **required** before the records are released. **Designee's Name as it appears on Driver's License:** _____
Please return completed form to: Vail Valley Surgery Center PO Box 1270, Vail, CO 81658 Email: vvscmedrec@vailhealth.org Tel: (970) 569-7707; Fax: (970) 470-6603 Physical Locations: Vail Valley Surgery Center Vail 180 S. Frontage Rd. W. Vail, CO 81657 Vail Valley Surgery Center Edwards 320 Beard Creek Rd. Edwards, CO 81632 Hours: 6 AM – 6 PM Mon. – Thurs.; 6 AM – 5 PM Fri.

For VVSC Use Only:

Date Request Received:	Information Released By:	Completion Date:
MRN:	No. of Pages:	Fee Charged:
If Records Picked Up in Person, Date of Pick-up:	Signature of Patient/Designee:	Patient/Designee ID:

You are entitled to receive a copy of this Signed Authorization