



Colorado Mountain Medical

Doctors you know and trust.

A partner of Vail Health

50 Buck Creek Rd, Suite 200
PO Box 4330
Avon, CO 81620
HIM@CMMHealth.com
Phone (970) 926-6340
Fax (970) 926-6348

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

Release Medical Records FROM: <input type="checkbox"/> CMM	Release Medical Records TO: SELF <input type="checkbox"/> CMM
_____ Doctor / Hospital / Facility	_____ Doctor / Hospital / Facility
_____ Mailing Address / City / State / Zip Code	_____ Mailing Address / City / State / Zip Code
_____ Phone Number / Fax Number	_____ Phone Number / Fax Number

RECORDS TO BE DISTRIBUTED BY:

- Fax
 Mail (Paper Copy Encrypted USB/CD)
 Encrypted Email
 Pick-Up (Avon Vail Eagle)

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 test results (AIDS).
 Authorize Release Do NOT Authorize
 Not applicable

INFORMATION TO BE RELEASED (check all that apply):

Date of Service range (month/year): From: _____ / _____ / _____ To: _____ / _____ / _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Mental Health Treatment | <input type="checkbox"/> Immunizations (<input type="checkbox"/> CO State <input type="checkbox"/> CMM internal) |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Clinic/Progress Notes |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Genetic Information | <input type="checkbox"/> Other Test Results | <input type="checkbox"/> Other: _____ |

INFORMATION TO BE USED FOR:

Continuity of Medical Care Damage/Claim Information Personal Other: _____

Authorization for the use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Colorado Mountain Medical, PC may not use or disclosure your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation form and returning the form to this office.

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above; I understand that once this information is disclosed, it may no long be protected by Colorado Mountain Medical. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon signing this authorization and that there may be a cost to copy records. I hereby recognize that providing an e-signature that this complies with the Federal Electronic Signatures in Global and National Comer Act (ESIGN Act) and the Uniform Electronic Transaction Act (UETA). Colorado Mountain Medical implements a two-step verification process to allow e-signatures on this legally enforced authorization. E-signatures must be dated, otherwise it will not be accepted, the signatory may request printed copy of the document at any time. Electronic signatures are not accepted for behavioral/mental health records.

AUTHORIZATION: I understand that 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 that this consent will expire 190 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

Signature of Patient or Authorized Representative

Date of Signature

Printed Name

Relationship to Patient (if applicable)