Glenwood **Medical** Associates

1830 Blake Ave. Glenwood Springs, CO 81601 • Phone (970) 945-8503 • Fax (970) 945-0253

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Processing time is 7 to 10 business days.

Processing fee is $14.00 for the first 10 or fewer pages - $0.50 for each page 11-40 & $0.33 for each additional page.

Patient Name: ______________________________ Last 4 Digits of SS#: _________ Date of Birth: _____/_____/______

Mailing Address:______________________________ City: ____________________ State/Zip: ______________

Phone (daytime): ____________________ Home: ____________________ Fax: ______________________

*** Please note, no records will be faxed other than to a covered entity ***

1. Physician or entity authorized to **RELEASE MY HEALTH INFORMATION:**
   Name: GLENWOOD MEDICAL ASSOCIATES – Attn: Medical Records Dept.
   Address: 1830 Blake Ave., Glenwood Springs, CO 81601
   Phone: (970) 945-8503 Fax: (970) 945-0253

2. Individual or Medical Clinic authorized to **RECEIVE MY HEALTH INFORMATION:**
   Name:____
   Mailing Address:______________________________________
   Phone:______________________________ Fax: ______________________________

3. **Date(s) or records being requested:** ______________________________________
   Information to be disclosed:
   Progress notes Laboratory X-ray reports Complete Chart Other: ____________________

PLEASE BE ADVISED THAT PART OF YOUR MEDICAL RECORDS MAY INCLUDE INFORMATION THAT IS RELATED TO CERTAIN LEGALLY PROTECTED INFORMATION (FOR EXAMPLE: SUBSTANCE ABUSE, ALCOHOL ABUSE, HIV STATUS, PSYCHIATRIC OR PSYCHOLOGICAL REPORTS). BY SIGNING THE AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS FORM, YOU ARE AUTHORIZING GLENWOOD MEDICAL ASSOCIATES RECORDS TO RELEASE ALL OR PART OF YOUR MEDICAL RECORD THAT MAY BE SENSITIVE TO YOU.

- I understand that if the person(s) or entity(ies) that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above *may* be re-disclosed and is no longer protected by those regulations. Therefore, I release Glenwood Medical Associates, Physicians, and employees there in, from all liability arising from this disclosure of *my* health information.
- I understand that I may revoke this authorization at any time in writing, knowing that *any* previously disclosed information will not be effected.
- A copy of this authorization may be utilized with the same effectiveness as the original.

PURPOSE FOR WHICH THIS DISCLOSURE IS TO BE MADE:

A. *Continuance of Care reasons.*
Referred to an external physician by my GMA physician/provider.
Requesting records from my previous provider as a new patient to GMA.

B. *Reason(s) for leaving GMA practice (please check all that apply):*
Relocating/moved outside of the area.
Seeking a different approach to care not offered at GMA (please specify) ______________________________
Transitioning to another local provider for convenience reasons (e.g. hours of operation, parking, etc.)
Cost considerations (e.g. affordability, insurance coverage, etc.)
Other (please explain) ____
Would you like to speak with the GMA practice administrator about your decision to change practices? Yes____ No___

SIGNATURE: (Patient or Legal Representative) **TODAYS DATE: (Expires six (6) months from this date)**

Authorization and Patient Identification verified by: ________________________ **(GMA employee initials)**