



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: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

2. Individual or Medical Clinic authorized to **RECEIVE MY HEALTH INFORMATION:**

Name: GLENWOOD MEDICAL ASSOCIATES – Attn: Medical Records Dept.

Mailing Address: 1830 Blake Ave., Glenwood Springs, CO 81601

Phone: (970) 945-8503 Fax: (970) 945-0253 (Please do not fax records more than 30 pages)

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.

**SIGNATURE:** (Patient or Legal Representative)

**TODAYS DATE:** (Expires six (6) months from this date)

• Authorization and Patient Identification verified by: \_\_\_\_\_ (GMA employee initials)