TETON VALLEY HEALTH CARE
Your Healthcare Elevated

Medical Record Release Form

Pursuant to HIPAA reg. 45 CFR 164.508, I hereby request and authorize Teton Valley Health Care to disclose copies of protected health information for services provided to:

Patient's Full Name: _____ **Date of Birth:** _____

Mailing Address: _____**Phone**:_____

I authorize Physician's Office/Hospital:_____

Address: _____

Phone: _____Fax:_____

to release my medical information to**:** _____

Address: _____

Phone: _____Fax:_____

Release records dated From:_____To: _____Expiration Date:_____

(Unless specified above, this release will only be good for time period it takes to process this request. An additional release will be required to further release this record set at another time frame and/or to another recipient).

Purpose of Release: _____

Please send copies of: ***(check ALL that are desired)***

☐**All Records** ☐**ED Report** ☐**X-Rays** ***(☐CD only)*** ☐**Lab Results** ☐**Consultations**

☐***Psychotherapy/Counselor Notes <u>Only:</u>*** ***(Psychotherapy records* can only be released by themselves *so* if additional records are needed to be released, an additional release form will need to be completed.)**
(Per 164.508.a.2 OCR/HIPAA Privacy Regulation)
☐**Other Records:**_____

***<u>Patient rights concerning this authorization</u>*:** You may refuse to sign this authorization. We will not condition treatment on whether you sign the authorization unless the authorization is for the use or disclosure of information for research-related treatment, or unless your treatment is solely for the purpose of disclosing information to a third party. You may revoke this authorization at any time unless we have taken action in reliance on the authorization. To revoke this authorization, you must submit a written request to: Teton Valley Health Care; ATTN: Medical Records Department 120 East Howard Avenue; Driggs, ID 83422 or give an expiration date of this release above. If information disclosed pursuant to this authorization is re-disclosed by the recipient, it may no longer be protected by applicable law.

I have read and understand this authorization, including my rights concerning it, as set forth above. I realize Teton Valley Health Care may not provide access to certain types of medical records that are protected by law, such as psychotherapy notes, and may require a separate release. I understand that regulation allows entities up to 30 days to respond to, and to process my request, with the option of using an extension for an additional 30 days, if needed. If access is denied, I have the right to appeal that decision by contacting Teton Valley Health Care Administration or the Secretary of HHS. I also realize that I may be charged for copies or summaries of my PHI and will need to pay prior to receipt.

Request(s) may be faxed to 208-354-2829 or mailed to above address

_____/_____ /_____

Signature of Patient or Legal Representative **Relationship to Patient** **Date**

ONLY THE PATIENT OR HIS/HER LEGAL REPRESENTATIVE MAY SIGN. IF THE PATIENT IS UNDER 18, ONLY A PARENT, HIS/HER LEGAL REPRESENTATIVE OR A LEGAL GUARDIAN MAY SIGN.

<u>Medical Records Use Only:</u>

☐**Copy to Patient Date:**_____☐**Faxed Date:**_____☐**Mailed Date:**_____**Completed by:**_____