Teton Valley Health
Where Everyone Matters

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient name: _____ Birth Date:_____

Mailing Address: _____ City/ State/ Zip:_____

PURSUANT TO HIPAA REG. 45 CFR 164.508, I HEREBY AUTHORIZE TETON VALLEY HEALTH TO

[ ] RELEASE TO [ ] OBTAIN FROM

Name:_____

Address: _____

City:_____ State: _____ Zip Code:_____

Fax:_____ Phone:_____

FORMAT: [ ] MAIL [ ] PICK UP [ ] FAX [ ] SECURE EMAIL: _____

Dates of treatment from: _____ to: _____ Expiration: _____
(12 month maximum from date of signature)

[ ] All Records [ ] Consultations [ ] Lab Reports [ ] Radiology Reports & Images [ ] ED Reports
[ ] Immunizations [ ] Other: _____

If expiration date is not specified, this request will expire in 365 days from the date of signature.

Patient rights concerning this authorization: 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; 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 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 Administration or the Secretary of HHS. I also realize that I will be charged 25¢ per page for copies or summaries of my PHI and will need to pay prior to receipt.

_____

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.

Staff Use Only:
[ ] Info already released [ ] Needs to be released [ ] Faxed Date: _____ [ ] Mailed Date: _____