GRAND RIVER MEDICAL CLINICS
501 AIRPORT ROAD RIFLE, CO 81650
PHONE (970)625-1100 FAX (970)625-0725

grand river Health
exceptional healthcare locally

Authorization for Release of Protected Health Information

Patient Information:	Legal Name:_____ DOB:_____ Address: _____ Phone #:_____ City:_____ State: _____ Zip:_____ Maiden or Prior Name: _____ SS#:_____
Provider Who Has Your Medical Information:	Provider/Facility:_____ Address:_____ City:_____ State: _____ Zip:_____ Phone:_____ Fax:_____
Disclose Information To:	Provider/Facility:_____ Address:_____ City:_____ State: _____ Zip:_____ Phone:_____ Fax:_____
Clinic Information To Be Released:	☐ Office Notes ☐ Physical ☐ Pathology Reports ☐ Lab Reports ☐ Immunization Record ☐ Radiology Reports ☐ All Clinic Records ☐ Other:_____
Limit Records	Time Period From:_____ To:_____
Purpose of Release:	☐ Patient Request ☐ Legal ☐ Insurance Claim ☐ Consult/Referral ☐ Transfer to New Physician ☐ Other:_____
Revocation:	I understand that I may revoke this authorization at any time by sending written notice to the health care facility/provider noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a beach of my rights to privacy.
Authorization:	I hereby authorize the above facility/provider to disclose medical information concerning the above name patent to the party identified in the section entitled "Disclose Information To". I understand that the information to be released might include information regarding treatment of mental health, alcohol and drug usage, HIV, and AIDS related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and might no longer be protected. I further understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. _____ _____ Signature of Patient or Representative Date _____ If signed by representative, please state authority to act on behalf of the patient *This authorization will expire one year from the date of signature. *I understand I am not required to sign this authorization if I do not wish to release my records
For Office Use Only:	Release method: ☐ Faxed To:_____ ID Verified:_____ ☐ Picked up on:_____ # Of Pages:_____ ☐ Mailed To:_____ Released by:_____

A photocopy/fax of this authorization will be treated in the same manner as an original