Request by Patient for Access to Their Protected Health Information

All patients will have the ability to review, inspect and/or obtain a copy of their Protected Health Information in their Medical Health Record. You will be required to present identification at time of request. This authorization will expire one year from the date of signature and includes test results (lab, diagnostic images, and pathology), immunization records and/or office visit notes for a specified date. If you would like a copy of your entire medical record you will be asked to complete a medical records release.

Initial: _____

Authorization to Discuss, Obtain or pick up a copy of treatment notes, test results and/or prescriptions

I, _____ authorize the following people to receive in written form and/or discuss verbally information pertaining to my care, such as test results (lab, diagnostic images, and pathology), immunization records and/or office visit notes for a specified date. This authorization does not include release of a complete copy of my medical record. I also authorize the following people to pick up prescriptions on my behalf from the clinics.

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Name: _____Relationship:_____Phone:_____

Right to Revoke: I understand that I have the right to revoke this Authorization in writing at any time subject to the exceptions stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. In addition, I must sign my request and then mail or deliver my request to Grand River Hospital District
ATTN: Medical Records at 501 Airport Road Rifle, Colorado 81650.

Exceptions to Right of Revocation: I understand that my written revocation will not affect the ability of the Hospital to continue to use or disclose my health information to the extent that it has already acted in reliance on this Authorization. For example, the Hospital cannot rescind disclosures it has already made, and may use my health information as necessary to bill and collect for services rendered.

Initial: _____

Patient Name: _____ Date of Birth: _____

Signature_____ Date: _____

Printed Name: _____Relationship to Patient: _____

☐ Acknowledgement refused. Reasons for refusal: _____

Disclaimer:

The information provided in this document does not constitute, and is no substitute for legal or other professional advice. Users should consult their own legal or other professional advisors for individualized guidance regarding the application of the law to their particular situations, and in connection with other compliance related concerns.