MONTROSE
MEMORIAL HOSPITAL
800 South Third Street
Montrose, CO 81401
970-249-2211

AUTHORIZATION FOR MEDICAL RECORDS

By signing this form you are authorizing Montrose Memorial Hospital to release the identifiable health information to the person/entity listed. Items not checked are considered to be non−applicable or specifically not authorized for release. MMH may not condition treatment, payment enrollment or eligibility for benefits on whether you sign this authorization. Please allow 7−10 business days.

1. Patient Name: _____ **2. Date of Birth:** _____

3. Organization releasing information

Montrose Memorial Hospital
800 South Third
Montrose, Colorado 81401
970−240−7365 phone
970−240−7761 fax

4. Person/Entity receiving information:

_____
_____
_____

Phone Number: _____

5. Specific description of information

- ❑ All Dictated Provider Reports
- ❑ Operative Report
- ❑ History and Physical
- ❑ Discharge Summary
- ❑ ER Report
- ❑ Respiratory
- ❑ Laboratory results
- ❑ Pathology Report
- ❑ Anesthesia Record/Reports
- ❑ Birth Records
- ❑ EMG, Nerve Conduction
- ❑ Cardiology Reports/ EKG
- ❑ Complete Medical Record − Copy charges may be assessed
- ❑ Radiology Reports
  - ❑ X−Ray
  - ❑ CAT Scan
  - ❑ MRI/MRA
  - ❑ Ultrasound
  - ❑ Mammography
- ❑ Radiology Images on CD
  - ❑ X−Ray
  - ❑ CAT Scan
  - ❑ MRI/MRA
  - ❑ Ultrasound
  - ❑ Mammography
- ❑ Therapy Type_____

6. Date(s) of Service: _____

7. Purpose of Release: ❑ At my request (patient initiator of auth) ❑ Purpose of authorization− _____

8. I request the records be : ❑ CD ❑ Paper ❑ Sent via encrypted email − _____

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.

9. I understand these records may include information relating to (check if applicable)

- ❑ Alcohol and/or drug use
- ❑ Psychiatric care or consultation
- ❑ Genetic Testing
- ❑ Child abuse
- ❑ Sickle cell anemia
- ❑ AIDS or HIV testing or treatment

10. Expiration and Revocation: I understand that this authorization will expire

❑ 1 year from the date of signature ❑ Date _____/_____/_____ ❑ Duration of specific event_____

I understand that I may revoke this authorization at any time by notifying Montrose Memorial Hospital in writing. If choose to revoke this authorization, it will not have any effect on any actions taken prior to revocation.

11. Redisclosure: I understand that if the person who is authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy regulations, and may be redisclosed without my knowledge

12. *Charge for copies: I understand that in accordance with Colorado State law,6 C.C.R 1011−1 Chapter 2, Part 5.2.3.4, I may be charged for copies of my medical records. MRO Corp. will bill for any fee based copies.

13._____ _____ _____

Signature of patient/guardian/personal representative | **Relationship to patient** | **Date signed**

Office use only:
❑ ID Verified

MR#_____
Date Completed: _____ Initials: _____
MRO Request #: _____

MRREQ