HEALTH INFORMATION SHARING FORM

PHONE: (970)-871-1323
FAX: (970)-871-9177
EMAIL: medrecords@steamboatfamilydoc.com

Family Medicine
personalized care

www.steamboatfamilydoc.com
501 Anglers Drive, Suite 201
Steamboat Springs, CO 80487

Obtain records from: ☐ other physician facility ☐ other please specify_____

Release records to: ☐ self ☐ other physician facility ☐ other please specify _____

Patient name (print) _____ Date of Birth _____

Social Security # _____

Release Records to or Obtain Records from:

_____
Name

_____
Address

_____
City State Zip

(____) _____ (____) _____
Phone Fax

General authorization: I authorize the above named health care provider to release the information specified below to the organization, agency or individual named on this request. I agree to pay the facility's reasonable charge for copying any documents and I understand that the facility may require up to 10 days time to copy and release records.

Information Requested

- ☐ **Copy of complete medical record**
- ☐ Copy of history & physical
- ☐ Discharge summary
- ☐ Operative reports
- ☐ Copy of outpatient reports
- ☐ Confer by oral and/or written communication with other person(s) regarding my medical condition
- ☐ Other –please specify: _____

Condition(s) and dates of care covered

- ☐ All past admissions or care by this office as of date of signature
- ☐ Limited to the treatment date and for conditions described below

_____
_____

Specific Exclusions: I specifically request the following information excluded from release:

- ☐ Drug abuse or alcohol abuse, if any
- ☐ HIV information
- ☐ Psychological or psychiatric conditions
- ☐ Diagnosis of sexually transmitted diseases (STD's)

Purpose or Need for Authorization:

- ☐ Insurance or payer claim
- ☐ Change of doctor
- ☐ Other, please specify: _____

Expiration of Revocation of Authorization: I understand that I may revoke this authorization in writing at anytime except to the extent that action has already been taken to comply with it. I understand that this authorization will not apply to admissions or care provided after the date of my signature. Even if I do not revoke this authorization in writing this authorization will automatically expire

- ☐ 180 days from the date of my signature
- ☐ On the following date _____

_____ _____
Signature of Patient or Legal Guardian or Designated Representative Date