MONTROSE
REGIONAL HEALTH

800 S. 3rd Street
Montrose, CO 81401

AUTHORIZATION FOR MEDICAL RECORDS

By signing this form you are authorizing Montrose Regional Health 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. MRH 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. DOB:**_____ **3. Phone Number:**_____

4. Organization releasing information

Montrose Regional Health
800 South Third
Montrose, Colorado 81401
970-240-7365 phone
970-240-7761 fax
HIMROI@montrosehealth.com

5. Person/Entity receiving information:

❑ Mail-Address:_____
_____

❑ Email:_____

❑ Pickup-Person/Entity Receiving Records :_____
Phone Number of Person/Entity Picking Up Records:_____

❑ Other:_____Phone Number:_____

I request the records be: ❑ CD ❑ Paper
❑ Send via Encrypted Email:_____

Please consider 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.

6. Specific description of information

Location

❑ Therapy Type_____ ❑ Cardiology Clinic ❑ San Juan Cancer Center
❑ Montrose Lung & Sleep Center ❑ Alpine Women's Center ❑ Montrose Regional Health

❑ All Dictated Provider Reports
❑ Operative Report
❑ History and Physical
❑ Discharge Summary
❑ ER Report
❑ Respiratory
❑ Laboratory Results
❑ Pathology Report
❑ Anesthesia Record/Reports
❑ Radiology Reports
❑ Radiology Images on CD
❑ Other/Misc
❑ EMG, Nerve Conduction
❑ Cardiology Reports/ EKG
❑ COVID-19 Results
❑ Birth Records
❑ Complete Medical Record - **Copy Charges May Be Assessed.**

7. Date(s) of Service:_____

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

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

❑ Alcohol and/or drug use ❑ Genetic Testing ❑ Sickle cell anemia
❑ Psychiatric care or consultation ❑ Child abuse ❑ 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_____

If choose to revoke this authorization, it will not have any effect on any actions taken prior to revocation.

I understand that I may revoke this authorization at any time by notifying Montrose Regional Health in writing.
health care provider, the released information may no longer be protected by federal or state privacy regulations, and may be redisclosed without my knowledge

11. Redisclosure: I understand that if the person who is authorized to receive the information is not a health plan or

12. *Charge for copies: I understand that in accordance with Colorado State law,6 C.C.R 1011-1 Chapter 2, Section 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:
MR#_____
Date Completed: _____ Initials: _____
MRO Request #: _____ ❑ Imaging Disk given

❑ ID Verified

MRREQ