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.

1. Patient Name: _____ **2. DOB:** _____ **3. Phone #:** ( ) -
(ID Required)

4. Organization Releasing Information

Montrose Regional Health
800 South Third Street
Montrose, Colorado 81401
Fax: 970-240-7761
HIMROI@montrosehealth.com

5. Person/Entity Receiving Information

❑ Mailing Address: _____

❑ Email: _____

❑ Pickup-Person/Entity Receiving Records: _____

6. Specific Description of Information

Location: ❑ Montrose Regional Health Hospital ❑ Montrose Regional Health Associated Clinic

Clinic Name: _____

I request the records be: ❑ Electronic ❑ Paper

❑ Anesthesia Record/Reports	❑ EMG	❑ Progress Notes	❑ Discharge Summary	❑ SANE Exam Notes **Seperate Form Required**
❑ Birth Records	❑ ER Report	❑ Radiology Reports	❑ Office Notes	
❑ Complete Medical Record	❑ History & Physical	❑ Radiology Images **Must be picked up or mailed. (Software required to view)**	❑ Respiratory	❑ SANE Exam Photos **Seperate Form Required**
❑ Cardiology Reports/EKG	❑ Laboratory Results			

* SANE - Sexual Assault Nurse Examiner

7. Date(s) of Service - (Range Required) From: _____ To: _____

8. I Understand These Records May Include Information Relating To: (Check if Applicable)

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

9. Expiration And Revocation: I know that this permission is only good for one (1) year from the date I sign it. If I decide to take it back, it won't affect anything that happened before I took it back. I understand I can take back this permission anytime by writing a note to Montrose Regional Health.

10. Redisclosure: I know that giving permission to share my information is my choice. I also understand that if I share my information with someone who isn't a doctor or health plan, the privacy rules that usually protect it might not apply anymore. Once I share the information, it could be shared again.

❑ **I understand request may take up to 10 business days.**

11. _____ _____ _____
Signature of Patient/Guardian/Personal Representative | Relationship to Patient | Date Signed

Office use only:

MR# _____ MRO Request #: _____ ❑ ID Verified

ID Verified by (Signature): _____ Imaging Disk given by (Signature): _____ ❑ Imaging Disk given ❑ Completed

Date of Completion: _____