Garfield County Hospital District
Caring for Generations

Authorization To Release Patient Health Information

This form may also be used for a patient to authorize the use or disclosure of their health information to GCHD/Pomeroy Medical Clinic from another organization

Patient Name:____ Date of Birth:_____________

Previous Name (if applicable)____

Reasons(s) for this authorization (Check all that apply):

□ Personal Use □ Legal Use □ Continuing Care □ Transferring Care □ Other (specify):_________________________

Information to be Released FROM:		Information to be Released TO:	
□ **Garfield County Hospital District or Pomeroy Medical Clinic**		□ **Garfield County Hospital District or Pomeroy Medical Clinic**	
Organization or Company		**Organization or Company**	
Address	**City, State,Zip**	**Address**	**City, State,Zip**
Phone	**Fax**	**Phone**	**Fax**

Information to be Disclosed/Released

GCHD/Pomroy Medical Clinic may use or disclose the following healthcare information (check all that apply):

□ **Entire Completed Chart Record**

□ ED Reports □ **All** □ **Specify Dates**__________________

□ Clinic Visits □ **All** □ **Specify Dates**__________________

□ Radiology Reports □ **All** □ **Specify Dates**__________________

□ Lab Reports □ **All** □ **Specify Dates**__________________

□ Discharge Reports □ **All** □ **Specify Dates**__________________

□ Immunization/Shot Records

All Other Medical History (Please Specify):

Releasing Sensitive Information-IMPORTANT

A minor patient's signature is required to release the following information; 1. Information related to reproductive care such as birth control, pregnancy related services and Sexually Transmitted Diseases, including HIV/AIDS (age 14 and older) 2. Substance abuse and mental health treatment (age 13 and older).

□ Mental Health Treatment □ Sexually Transmitted Disease □ HIV/AIDS □ Alcohol/Drug Abuse Treatment

My Rights as a patient of GCHD/Pomeroy Medical Clinic

● Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form, in order to assure treatment or

● I can cancel this authorization at any time by writing to the Health Information Services Dept. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

● Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected be confidentiality laws.

This authorization will EXPIRE ONE YEAR FROM THE DATE SIGNED BELOW, unless another date or even is entered here:_______________

Signature of Patient/Legally Authorized

____

Signature of Patient or Legally Responsible Party (relationship to patient, if not patient) Date (Month/Day/Year)

____

Signature of Minor Patient if release pertains to (Releasing Sensitive Information-IMPORTANT) Date (Month/Day/Year)