

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Released from: Spanish Peaks Regional Health Center		Released to:	<input type="checkbox"/> Patient
<input type="checkbox"/> Spanish Peaks Regional Health Center	<input type="checkbox"/> Spanish Peaks Specialty Clinic		<input type="checkbox"/> Other Person/ Relationship: _____
<input type="checkbox"/> Spanish Peaks Family Clinic/LaVeta	<input type="checkbox"/> Spanish Peaks Ambulance		<input type="checkbox"/> Other Facility
<input type="checkbox"/> Spanish Peaks Women's Clinic	<input type="checkbox"/> Other _____		
Patient Name _____		Other Person / Facility Name _____	
Mailing Address _____		Mailing _____	
City _____	State _____	City _____	State _____
Zip _____		Zip _____	
Phone _____	Fax _____	Phone _____	Fax _____
Patient's Date of Birth: _____	Patient:	<input type="checkbox"/> Pick Up	<input type="checkbox"/> Fax <input type="checkbox"/> Mail
Email Address: _____	Other Person:	<input type="checkbox"/> Pick Up	<input type="checkbox"/> Fax <input type="checkbox"/> Mail
	Facility:	<input type="checkbox"/> Fax	<input type="checkbox"/> Mail

INFORMATION TO BE COPIED AND RELEASED (CHECK ALL THAT APPLY):

Date(s) of service: _____

<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Nurse Notes	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Medication Records	<input type="checkbox"/> Rehab Services
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Billing Records
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Lab/Pathology Results	<input type="checkbox"/> Non-SPRHC Medical Records
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Radiology Images	

I DO or I DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, alcohol, and/or drug abuse diagnosis, prognosis and treatment, and /or HIV(AIDS) testing and/or results, genetic testing/results, sickle cell anemia testing/results. *****NOTE: If this section is not completed, then records of this type, if they exist for this patient, will not be released. *****

THE PURPOSE FOR THIS RELEASE:

- Continuity of Medical Care
 Damage/Claim Information
 Personal Use
 Legal
 Other: _____

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected by federal privacy regulations and may be re-disclosed. I understand this authorization is voluntary and that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed, and a cost may be incurred for copying these records.

I understand this consent expires one year from the date of my signature unless otherwise specified as follows: _____

I understand that I can revoke my permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide written notice if I choose to revoke this authorization before the expiration date or event, and the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original.

FEES: Patient: \$6.50 all pages (CD or electronic delivery). Paper delivery: 1-10 are free, 11-99 pages are \$6.50, and 100 or more pages are delivered electronically only. To third-party recipient: \$18.53 (retrieval fee for pages 1-10) plus \$0.85 (each page 11-40) plus \$0.57 (each page over 40).

PLEASE ALLOW 10 BUSINESS DAYS FOR YOUR RECORDS REQUEST TO BE PROCESSED.

Signature of Patient/Representative

Date/Time

Signature of Witness

Date/Time

Name of SPRHC Staff person who released medical records: _____ Date: _____

OFFICE USE ONLY: Proof of Identification: _____

Number of pages released: _____ Completion Date: _____ Delivery method: _____

Name of staff working on this request: _____ Date request received: _____

PT. MRN / Account # _____

ROI # _____

REV: January2026