Salud Family Health

Health Information Release

Salud Family Health *P.O BOX 189 Frederick, CO 80530 Fax:303-227-6426*

You may be charged for your records to be released. Please see Fee Information on the back of this page.

Patient Information:		
Last Name:	First:	Middle:
Other Names Used:	DOB:	SS#:
Address:	City/State/Zip:	
Home Phone:	Cell/Work Phone:	
Email Address:		

I am authorizing health information to be sent **TO**:

Individual/Company/Agency/Facility:	
Name:	
Address:	
City/State:	
Phone:	Fax:

I am authorizing health information be released **FROM:**

Individual/Company/Agency/Facility:	
Name:	
Address:	
City/State:	
Phone:	Fax:

At this time, I am requesting that the following action be taken with my health records:

☐ **Provide a paper copy** ☐ **Share my information verbally only**

Purpose of Request:

☐ Personal ☐ Transfer Care ☐ Continuity Care/Referral ☐ Disability ☐ Worker's Compensation ☐ Care Management ☐ Payment ☐ Litigation ☐ Other_____

Information Authorized:

I hereby authorize the release of the following information indicated below:

Date Range From:_____ To: _____

☐ Physician Office Notes ☐ Cardiology/EKG Reports ☐ Medical Summary ☐ Lab/Pathology Reports ☐ Operative/Procedure Reports

☐ Radiology Reports (CT/MRI/X-RAY/Ultrasound) ☐ Billing/Payment Records ☐ Dental Records

☐ Other_____

☐ Behavioral Health Records-General ☐ Psychotherapy Notes ☐ Substance Use Records

(please describe in detail records to be released) _____

*Please note-Behavioral Health, Psychotherapy and Substance Abuse Records will only be released if these are specifically selected above and approved for release by the provider.

Authorization:

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility for benefits from Salud. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy and/or confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV), through Salud's general provision of health care. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Expiration:

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. This authorization will expire two (2) years from the signature date unless I specify a sooner expiration date.

Expiration Date:_____

Date: _____ Signature: _____

☐ Patient ☐ Parent/Guardian ☐ Authorized Representative (please describe authority to act for patient:

_____

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Fee Information:
PLEASE READ Fee information: Salud contracts with DataFile Technologies to copy and provide all records requested from our office. In the case of personal copies or transfers, DataFile will charge between $15 and $25 depending on the number of pages in the request. We reserve the right to charge the medical record state fee structure as set forth in the state statute for personal copies and for other requestors. Copy charges plus postage will be invoiced to you from DataFile Technologies, LLC with all of the necessary directions to receive your records. By signing this authorization, you are agreeing to pay DataFile Technologies for your records. DataFile Technologies will fulfill all requests within 24-72 hours once payment is received. Ask the front desk about using the Patient Portal to obtain some records such as labs and diagnostic imaging reports at no cost.

Instructions for Front of Form:
Person/Company/Agency/Facility: In the first box, please list the correct information for the person, company, agency, or facility you are requesting receive your records. In the second box, please list the correct information for the person, company, agency, or facility you are requesting to have your records sent to. **Release paper records or verbally share information** – These check box indicate how you would like your health records shared. By selecting "Provide a paper copy", a physical copy of your records will be released to the company/agency/facility listed in the previous section. If you select "Share my information verbally", you are only granting permission for the two entities or persons listed above to speak about your records. No paper records will be shared if this box is selected.
Purpose of Request: Indicate the reason for releasing the health information. Checking these boxes will assist us in tracking, assigning priority and who may be responsible for the cost of records (as appropriate). **Personal:** You are requesting a copy of your records for yourself. You can access and print these records for free using the MySalud Online patient portal. **Transfer of Care:** You no longer wish to continue your health care with Salud and are requesting to have your records transferred to another healthcare provider, or you are becoming a Salud patient and wish to have your records released to us. **Continuity of Care/Referral:** You or your provider have referred you for care that cannot be provided by Salud such as specialty care or hospital care. **Disability:** You are requesting records to be given to the state for your disability application, case, or renewal. You are requesting records that are only related to work injuries to be sent to your Workman's Comp agent or representative. **Care Management:** You are involved with a Care Manager at our organization and you need records sent to another organization. **Payment:** You are requesting copies of the payments that you made to Salud for care. **Litigation:** You are requesting for your records to be released to law firm or legal department for personal legal matters. **Other:** You are requesting records for something other than the options above. Cost for this request to be determined.
Information Authorized: Please indicate the Date Range for the records that you are requesting. Also indicate what kind of records you are requesting by checking the appropriate box(es). If you are requesting ALL of your records, please select "Other" and write ALL in the space provided. Please Note-Behavioral Health and Substance Abuse must be specifically checked if you want those records released as well.
Fee Information: Please read this section in its entirety. It has important information regarding the guidelines for charges associated with releasing your records. Patients can access some records such as labs, diagnostic imaging and provider notes at no cost through the MySalud Online Patient Portal. Please speak with an employee at the front desk for more details.
Authorization: This paragraph has detailed information regarding what you are authorizing when you complete and sign this request for records.
Expiration: This paragraph confirms that you read and understand our policies and guidelines regarding your request. It also informs you that this request is only valid for two (2) years unless you specify an earlier date.