DILLON SURGERY CENTER

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

MEDICAL AND BILLING RECORDS

PATIENT INFORMATION

Patient Name:	Date of Birth:

RELEASE MEDICAL RECORDS FROM: SEND MEDICAL RECORDS TO:

Doctor / Hospital / Facility	Doctor / Hospital / Agency / Facility / Person
Street Address, City, State, Zip Code	Street Address, City, State, Zip Code
Phone Number (Indentify country) / Fax	Phone Number (Indentify country) / Fax / Email

SEND MY RECORDS VIA:

☐ USPS Mail	☐ Secured Email	☐ Unsecured Fax Line
☐ Dillon pick up	☐ Verbal Authorization only	☐

SENSITIVE DATA: I understand that my medical records may contain information concerning my mental health and/or psychiatric treatment, drug and/or alcohol treatment as well as any HIV (AIDS) test results.

☐ I Authorize Release	☐ I Do Not Authorize Release	☐ This is Not Applicable to Me

INFORMATION TO BE RELEASED:

From Dates of Service (Month/Day/Year): to

☐ Anesthesia Records	☐ History Physical/Consult	☐ Entire Record Including Billing
☐ Discharge Summary	☐ Labs/Pathology Reports	☐ Entire Record Excluding Billing
☐ EKG/Cardiopulmonary Reports	☐ Operative Report	☐ Other Records (please Specify):
☐ Billings Information: ☐ Standard **OR** ☐ Operative Report		

INFORMATION TO BE USED FOR:

☐ Continuity of Medical Care	☐ Damage/Claim/Insurance	☐ Legal
☐ Personal	☐ Workers Compensation/Disability	☐ Other (please specify):

AUTHORIZATION FOR THE USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

THIS AUTHORIZATION WILL EXPIRE IN 180 DAYS. I understand that once this information is disclosed (released) that privacy protections may not apply to the recipient of the information and therefore, may not prohibit the recipient from re-disclosing it. I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. I understand that this authorization is voluntary and that there may be a cost to me for copies that are prepared in response to this request. A copy or facsimile of this form is considered as valid as the original. **I have read the above and authorize the disclosure (release) of my medical and/or billing records as stated above. I understand that this authorization is voluntary and that Dillon Surgery Center will not base treatment, payment, enrollment, or eligibility for benefits on my signing of this document.**

Signature of Patient/Patient Representative	Date
Printed Name of Patient/Patient Representative	Relationship to Patient

ADDITIONAL INFORMATION REGARDING YOUR REQUEST

REQUESTING MEDICAL RECORDS ON BEHALF OF ANOTHER PERSON: If you are requesting medical records for someone other than yourself, you may be required to provide additional documentation to show that you have a legal right to request the record set. Examples of these documents include Letters of Representation, Guardianship Papers, Affidavit of Heir at Law, etc. Please contact **Medical Records at 970-485-7070** to determine the documentation that you will be required to process your request.

REQUESTING YOUR RECORDS AT THE CONCLUSION OF YOUR VISIT AT DSC: If you are requesting at the conclusion of your visit, please be aware that there may be outstanding reports/documentation that may not be finalized at the time you receive the records you have requested. The records you receive should be considered incomplete and preliminary.

TURNAROUND TIME: Our average turnaround time for processing requests is 5 (five) business days plus shipping time. However, it may require 30 or more days to complete your request. Unless otherwise requested, records will be sent through US Mail. Records needed for medical emergencies will be faxed directly to a physician or medical facility. Please include your phone number on your request in case we need to contact you for additional information. For questions regarding requests for medical record copies, please contact Dillon Surgery Center at 970-485-7070 or vvscmedrec@vailhealth.org.

PICKING UP YOUR RECORDS: If you personally pick up your records or if you send a designee to pick up your records, **a photo identification** (driver's license, passport, etc.) will be **required** before the records are released.

Designee's Name as it appears on Driver's License:

PLEASE RETURN COMPLETED FORM TO:

Dillon Surgery Center
365 Dillon Ridge Road, Dillon, CO 80435 • PO Box 6230, Vail, CO 81658
Email: dscmedrec@vailhealth.org • Tel: (970) 485-7070; Fax: (970) 485-7039
Hours: 6 AM – 5 PM Monday - Friday

FOR SURGERY CENTER USE ONLY:

Date Request Received:	Information Released By:	Completion Date:
MRN:	Number of Pages:	Fee Charged:
Date of In-Person Pick-up:	Signature of Patient/Designee:	Patient/Designee ID: