Vail Integrative Medical Group

0105 Edwards Village Center, A203 * PO Box 2637 Edwards CO 81632
(970) 926-4600 Phone * (970) 926-4602 Fax

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Processing time is 7-10 business days
Processing fee is $14.00 for the first 10 or fewer pages, $0.50 for each page 11-40 & $0.33 for each additional page.

Patient Name _____ SS# _____ Date of Birth ___/___/_____
Mailing Address _____ City _____ State/Zip _____
Home # _____ Cell # _____ Fax # _____

1. Physician or entity authorized to **RELEASE MY HEALTH INFORMATION:**
   Name _____
   Address _____
   Phone _____ Fax _____
2. Individual or Medical Clinic authorized to **RECEIVE MY HEALTH INFORMATION:**
   Name _____
   Mailing Address _____
   Phone _____ Fax _____
3. Date(s) of records being requested _____ Information to be disclosed: check below
   □ Chiropractic Notes □ Physical Therapy Notes □ Massage Notes □ Dr. Gibson Notes
   □ Complete Chart □ Billing Records □ Other _____

PLEASE BE ADVISED THAT PART OF YOUR MEDICAL RECORDS MAY INCLUDE INFORMATION THAT IS RELATED TO CERTAIN LEGALLY PROTECTED INFORMATION (FOR EXAMPLE: SUBSTANCE ABUSE, ALCOHOL ABUSE, HIV STATUS, PSYCHIATRIC OR PSYCHOLOGICAL REPORTS). BY SIGNING THE AUTHORIZATION FOR THE RELEASE OF RECORDS, YOU ARE AUTHORIZING US TO RELEASE ALL OR PART OF YOUR MEDICAL RECORD THAT MAY BE SENSITIVE TO YOU.

- I understand that if the person(s) or entity (ies) that receive this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is not longer protected by those regulations. Therefore I release Vail Integrative Medical group (VIMG), its employees, and my physicians from all liability arising from this disclosure of my health information.
- I understand that I may revoke this authorization at any time in writing, knowing that any previously disclosed information will not be effected.
- A copy of this authorization may be utilized with the same effectiveness as the original.

PURPOSE FOR WHICH THIS DISCLOSURE IS TO BE MADE:

1. Continuance of Care Reasons:
   □ I was referred to an outside physician by my VIMG physician/provider.
   □ I am a new patient to VIMG – requesting records from my previous provider.
2. Leaving VIMG Practice Reasons:
   □ Moving/Moved outside the area. □ Found a better provider outside VIMG.
   □ Unsatisfied with services at VIMG. □ Transfer to another provider that participates with my health plan.
   □ Other (please explain) _____

→ _____ → _____
SIGNATURE (Patient or Legal Representative) TODAY'S DATE (Expires six (6) months from this date)

* Authorization and Patient Identification Verified by: _____
(VIMG Employee Initials)