Internal Medicine
Associates of the Grand Valley
Community HOSPITAL

607 28 1/4 Road
Grand Junction, CO 81506
Phone (970) 243-3300
Fax (970) 243-4464

Under HIPAA regulations, we may no longer discuss or disclose any information about your health care without written permission. You must sign this form in order to authorize the release of your information

Authorization for the Use or Disclosure of Protected Health Information

To the Patient:
As required by the Health Insurance Portability and Accountability Act of 1996 Internal Medicine Associates of the Grand Valley, may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

WHO? To whom are you releasing the right to receive your Protected Health Information?
I authorize the following persons to receive these disclosures of my health information:

1._____
2._____
3._____

WHAT? WHAT specific records, if any, do you want released? Specific? All?
I, _____ (print patient name) hereby authorize the use, disclosure, or both, of the following health information that pertains to me:

1._____
2._____
3._____

WHY? Emergencies? To inform those you give permission to obtain records? To discuss your health care with whomever you list above; to discuss general health reports or issues related to your care, etc. for the following purpose(s):
WHY do you want them released, for what purpose?

1._____
2._____
3._____

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I authorize Internal Medicine Associates of the Grand Valley, to make these disclosures of my health information.

I understand that once my protected health information (PHI) is disclosed, the person or organization that I have authorized the release to (recipient) may re-disclose it. Privacy laws may no longer protect it.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Internal Medicine Associates of the Grand Valley, 607 28 1/4 Road, Grand Junction, CO 81506** . I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire on _____ Date.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that Internal Medicine Associates of the Grand Valley, will receive compensation for the uses and disclosures that I have authorized.

_____ _____

Signature Date

REVOCATION:

I hereby revoke this authorization. (In the event you elect to **STOP** allowing access to your records, you **MUST** sign this authorization to cease your prior consent. That means you will have to come back to this office and sign this release.

_____ _____

Signature Date