Town Clinic of Crested Butte, PLLC

P.O. Box 1546
Crested Butte, CO 81224

214 6th Street, Suite 1
(970) 349-6749

Eric Thorson, M.D.

General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information: ~ please print ~

Patient Last Name:_____First Name:_____M.I.____
Address:_____City:_____State:_____ZIP:_____
Social Security Number:_____Date of Birth:___ ___/___ ___/___ ___
Cell Phone:_____Home Phone:_____Work Phone:_____

I authorize the custodian of records of:_____or other person/entity (specifically describe) to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ X-ray/radiology records
- ☐ Abstract/Summary
- ☐ Other (describe specifically):_____
- ☐ Laboratory/pathology records
- ☐ Billing records
- ☐ Pharmacy/prescription records

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s):_____

Please send the records listed above (use additional sheets if necessary):

From Physician:__Dr. Eric Thorson_____To: _____
Clinic Name:_Town Clinic of Crested Butte, PLLC_Clinic Name:_____
Address:_214 6th St., Suite 1; PO Box 1546_____Address:_____
City: Crested Butte_State:_CO_ZIP: 81224_____City: _____State:_____ZIP:_____
Phone:_970.349.6749_____Fax:_888.540.4013___Phone:_____Fax:_____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For payment/insurance
- ☐ Other (describe specifically)_____
- ☐ For my health care
- ☐ For employment purposes

This authorization shall expire no later than:__ __/__ __/__ __ or upon the following event _____ (*whichever is sooner*), and may not be valid for greater than one year from the date of signature for _____(*state name*) medical records. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient or personal representative | Date

_____ _____
Printed name of patient or personal representative | Relationship to patient and/or authority to sign for patient, (i.e., parent, guardian, power of attorney for healthcare, executor)

~ A copy of this signed authorization must be given to the individual. ~