VAIL-SUMMIT
ORTHOPAEDICS & NEUROSURGERY

Request for Patient Access to Health Information

I, (print name) ____ Date of Birth_____/_____/_____ hereby request to inspect or obtain a copy of my medical records from Vail Summit Orthopaedics and Neurosurgery (VSON). Under federal law 104-191, known as HIPAA, I am entitled to such access upon written request. **Under Colorado State law, VSON has 15 calendar days to fulfill my request.**

SECTION 1

I would like to:

____ Obtain a copy of my Personal Medical ***IMAGES*** ****please complete section 2***

____ Obtain a Copy of my Personal Medical ***RECORDS*** ****please complete section 2***

____ Allow (print name) ____ to access my Personal Medical Records until further notice.
Choose one or both: ☐ Verbal Discussion with team/provider. ☐ May obtain printed records on my behalf.

____ Access and Inspect my Personal Medical Records (Done in Medical Office)

Please choose one:

☐ All of the medical Records

☐ The portion of the Records Concerning: ____

SECTION 2

I request that confidential communications be sent via one, or multiple, of the following means:

____ Send ***IMAGES*** **electronically** via PowerShare to Email or Practice Location (for **Medical Locations**):

____

____ Send ***IMAGES*** **electronically** via Efferent Smart Share to Email (for **Patients**):

____

*******You can download Images to a CD-ROM, Desktop, Flash-Drive*******

___ Send ***RECORDS*** **electronically** via E-Mail or FAX (***quickest!***):

____

____ Send ***RECORDS*** to an address via USPS, UPS, FedEx or Registered Mail

Address:____

____ Pick up ***RECORDS*** at the ☐ Vail ☐ Frisco ☐ Edwards Office

____ Pick up **CD-ROM OF IMAGES MUST INITIAL BELOW** at the ☐ Vail ☐ Frisco ☐ Edwards Office

____ I understand that I will be charged a fee of $6.50 per CD-ROM requested. CD-ROMs of images will not be made until payment has been received. To make payment please call 970-477-7432.

If you have questions on how to properly fill in this form or to make payment, please call 970-477-7432.
Once complete please fax this form to 866-725-4659 or email it to roi@vsortho.com or drop it by a VSON location.

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***PLEASE NOTE THAT YOU MAY REQUEST TO HAVE YOUR HEALTH INFORMATION SENT VIA ANY OF THE ABOVE MEANS, HOWEVER YOU MUST INITIAL EACH OF THE FOLLOWING:**

____ *I understand that having my personal health information sent via any of the following means may put my information at greater risk of being disclosed to unintended parties as no fault of Vail Summit Orthopaedics and Neurosurgery.*

_____ *With this request, I agree that the security and confidentiality of my confidential medical information that is sent to an alternate address or via an alternate means is my responsibility alone. If Vail Summit Orthopaedics and Neurosurgery acts on my requests and sends communications as I have specifically directed them to do in writing. I agree that Vail Summit Orthopaedics and Neurosurgery cannot and shall not be responsible for any inadvertent disclosures that may occur as a result of fulfilling my written request.*

_____ *Under federal law, Vail Summit Orthopaedics and Neurosurgery is required to accommodate "reasonable" requests for communicating confidential medical information to me via alternate means. They may deny my request if they determine that my request is unreasonable.*

_____ *If an expense is involved in fulfilling my request, I will be charged that expense. If the expense involved is unreasonable or burdensome, Vail Summit Orthopaedics and Neurosurgery may deny my request on that basis alone.*

My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form:

- To take part in a research study;

  or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I revoke this authorization, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization:

- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it.
Privacy laws may no longer protect it.

Signed: ____ **Date:** ______________________________

Print Name: ____ **Telephone:** __________________________

If not signed by the patient, please indicate your relationship to the patient:

☐ Parent or Guardian or conservator for an incompetent patient

☐ Beneficiary or personal representative of deceased patient

☐ Other (specify) ____

This authorization ends*: ☐ On (date): __________________

☐ When the following event occurs: ____

*If no end date is provided, this authorization will expire one year from the date of signing

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