☐ University of Colorado Hospital
☐ Poudre Valley Hospital
☐ Medical Center of the Rockies
☐ Memorial Hospital
☐ Colorado Health Medical Group

UNIVERSITY of COLORADO HEALTH

MRN# _____
CSN/FIN# _____

Authorization to Disclose Protected Health Information

Patient Name: _____ Formerly Known As: _____ Birth Date: _____

Address: _____ City/State: _____ Zip: _____ Phone #: _____

Purpose of Request: ☐ Continuation of Care ☐ Personal ☐ Legal ☐ Insurance ☐ Other: _____

I authorize release to: _____ Phone Number: _____

Name/Facility: _____ Fax Number: _____

Address: _____ City/State: _____ Zip: _____

Date of Service range (month/year): From: _____ To: _____

___ Abstract (Physician notes, Lab, Radiology, Cardiology)	___ Immunization Record
___ Billing/UB04	___ Laboratory Results
___ Clinic/Progress Notes	___ **Mental Health Treatment***
___ Complete (All records, notes, meds, flowsheets, etc.)	___ Operative Note
___ Discharge Summary	___ Other: _____
___ **Drug/Alcohol Treatment***	_____
___ Emergency Room Report	_____
___ Facesheet	___ Radiology Reports
___ **Genetic Information***	___ Radiology Images
___ History and Physical	___ **Sickle Cell***
___ **HIV/AIDS Information***	___ **STD/Communicable Disease***

***I hereby consent to disclose the above bolded/specialized information.** _____
Patient's Signature required

****

1. **Requests will be processed within 10 business days.**
2. I authorize the release of my medical record, including photographs.
3. This authorization is voluntary and the disclosure is made at my request.
4. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. Multiple requests are authorized if the purpose of the request remains the same.
6. I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
7. I need not sign this form to ensure health care treatment.

I request this authorization to expire on _____ or 180 days from the date signed below and **covers only treatment for the dates specified above.**

I am also aware fees, outlined below, for copy services may apply. NOTE: Fees/charges will comply with all laws and regulations applicable to the release of information. Standard copying fees are as follows:

No charge for pages 1-10 .50 cents for each page from 11-40 .33 cents for each additional page

Additionally, an initial set of radiological films/CD-ROM can be provided at no cost to a patient for physician or facility referral. However, **a fee of $5.00 per sheet of film and $7.00 per CD-ROM will be charged for additional copies.**

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED**.

_____ _____
Signature of Patient or Legal Representative **Date**

For HIM Office Use Only

ID: ☐ Driver's License _____ ☐ State ID _____ ☐ Military ID _____

If signed by legal representative, indicate documentation: ☐ Death Certificate ☐ Power of Attorney ☐ Living Will

Processed by: _____ Date: _____ Mailed/Faxed/Given by: _____