Medical Record #: _____

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

uchealth

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

OBTAIN FROM: (Releasing Facility)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

RELEASE TO: (Receiving entity)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by University of Colorado Hospital. I understand this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

Date of service range (month/year): From _____ to _____

Information to be reviewed:

- ☐ In electronic medical record only
- ☐ During patient admission/visit
- ☐ In health information department

Information to be released (check all that apply):

- ☐ Emergency Room Report
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ History and Physical Clinic
- ☐ Clinic/Progress Notes
- ☐ Mental Health Treatment
- ☐ Drug/Alcohol Treatment
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Immunization Records
- ☐ Genetic Information
- ☐ HIV/AIDS Information
- ☐ X-Ray Films
- ☐ Other:

_____

_____

_____

Information is to be used for:

- ☐ Continuity of medical care
- ☐ Remote Second Opinion
- ☐ Damage/claim information
- ☐ Other
- ☐ Personal Use

AUTHORIZATION

I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy or facsimile of this form is to be considered as valid as the original.

_____ _____

Signature of Patient or Authorized Representative | Date of Signature

_____ _____

Printed Name | Relationship to Patient (if applicable)

PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS

I hereby acknowledge that I the patient/authorized representative have reviewed and/or received _____ photocopies of the medical records from the University of Colorado Hospital for the above named patient.

_____ _____ _____ _____

Date | Signature | Date | Witness Signature