



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

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: _____

<input type="checkbox"/> Abstract (Physician notes, Lab, Radiology, Cardiology) <input type="checkbox"/> Billing/UB04 <input type="checkbox"/> Clinic/Progress Notes <input type="checkbox"/> Complete (All records, notes, meds, flowsheets, etc.) <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Drug/Alcohol Treatment* <input type="checkbox"/> Emergency Room Report <input type="checkbox"/> Facesheet <input type="checkbox"/> Genetic Information* <input type="checkbox"/> History and Physical <input type="checkbox"/> HIV/AIDS Information*	<input type="checkbox"/> Immunization Record <input type="checkbox"/> Laboratory Results <input type="checkbox"/> Mental Health Treatment* <input type="checkbox"/> Operative Note <input type="checkbox"/> Other: _____ <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Sickle Cell* <input type="checkbox"/> STD/Communicable Disease*
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***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: <input type="checkbox"/> Driver's License _____	<input type="checkbox"/> State ID _____	<input type="checkbox"/> Military ID _____
If signed by legal representative, indicate documentation: <input type="checkbox"/> Death Certificate <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Living Will		
Processed by: _____	Date: _____	Mailed/Faxed/Given by: _____