☐ University of Colorado Hospital
☐ Poudre Valley Hospital
☐ Medical Center of the Rockies
☐ Longs Peak Hospital
☐ Memorial Hospital
☐ UCHealth Medical Group

MRN# _____
CSN/FIN# _____

☐ Broomfield Hospital
☐ Grandview Hospital
☐ Yampa Valley Medical Center

## 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: _____

**If released to self, please select method of release:** ☐ email _____ ☐ mail ☐ MyHealthConnection

| | |
|---|---|
| ☐ Billing/UB04<br>☐ Clinic/Progress Notes<br>☐ Discharge Summary<br>☐ **Drug/Alcohol Treatment***<br>☐ Emergency Room Report<br>☐ Facesheet<br>☐ **Genetic Information***<br>☐ History and Physical<br>☐ **HIV/AIDS Information***<br>☐ Immunization Record<br>☐ Laboratory Results | ☐ **Mental Health Treatment***<br>☐ Operative Note<br>☐ Other: _____<br>_____<br>_____<br>☐ Radiology Reports<br>☐ Radiology Images<br>☐ **Sickle Cell***<br>☐ **STD/Communicable Disease***<br>☐ Visit Record (includes emergency room records, Provider Notes and Reports, Health Data, Medical History, Medicine and Allergy Lists, Test Results)<br>☐ Visit Summary (Provider Notes and Reports, Test Results) |

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

**********

1. **The State allows 10 business days request processing.**
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.

**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: _____