



Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	City, State, Zip Code	Telephone Number
I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.		
Release by: Facility _____ Address _____ City, State, Zip Code _____ HIM Phone/Fax Numbers _____	Release to: Organization, Agency, Individual _____ Attn: _____ Address _____ City, State, Zip Code _____	
Treatment Date(s): _____ Purpose: <input type="checkbox"/> Further Medical Care <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Personal Use <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Marketing/Fundraising <input type="checkbox"/> Other: _____	Type of Disclosure Authorized & Delivery Instructions: <input type="checkbox"/> Provide copies of records to organization/agency/individual <input type="checkbox"/> Mail records directly to address above <input type="checkbox"/> Call to pick-up records: _____ <input type="checkbox"/> Fax records to: _____	
Pertinent Protected Health Information Allowed to be Included: <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Radiology <input type="checkbox"/> Special Studies <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> History & Physical/Consult <input type="checkbox"/> Outpt Record <input type="checkbox"/> Medication Records <input type="checkbox"/> Operative Report <input type="checkbox"/> Progress Notes <input type="checkbox"/> Psych Health Records <input type="checkbox"/> Labs <input type="checkbox"/> Physician Orders <input type="checkbox"/> Other (specify): _____		
*Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A Patient Authorization to Disclose Psychotherapy Notes must be completed.		
Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer. Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____ Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS). For Marketing/Fundraising Purposes Only, if applicable: I understand that Centura Health <input type="checkbox"/> will <input type="checkbox"/> will not receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.		
SIGNATURE: _____ DATE: _____ <small style="margin-left: 100px;">Patient (Parent or Legal Guardian)</small> Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law. Relationship (if other than patient): _____ <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Death Certificate Name of individual signing on behalf of patient: _____ Verification: <input type="checkbox"/> Drivers License # _____ <input type="checkbox"/> Other Appropriate ID: _____		
OFFICE USE ONLY: Attach copies of required identification. Number of pages released: _____ Completion date: _____ Delivery method: _____ Name of individual who received request: _____ Date received: _____ Patient Medical Record Number / Account Number: _____ / _____		