



### Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of SSAN
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**I hereby authorize the facility listed below to disclose/release the Protected Health Information in this request to the organization, agency, or person named below:**

<p><b>Release Information to:</b></p> <p>_____</p> <p>Organization, Agency, Individual</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip</p> <p>_____</p> <p>Phone Number</p> <p><b>Information Released by:</b></p> <p>_____</p> <p>Organization, Agency, Individual</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City, State, Zip</p> <p>_____</p> <p>Phone Number</p>	<p><b>Protected Health Information Allowed to be included:</b></p> <p>Discharge Summary</p> <p>Treatment Summary</p> <p>History and Consults</p> <p>Lab Work</p> <p>Encounter Notes</p> <p>Medication Records</p> <p>Entire Medical Record</p> <p>Other (specify)</p> <p><b>*Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A separate patient authorization to disclose psychotherapy notes must be completed.</b></p>
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<p><b>Treatment Date(s):</b> _____</p> <p><b>Purpose:</b></p> <p>Care Coordination      Workers' Comp</p> <p>Personal Use              Insurance</p> <p>Legal                         Marketing</p> <p>Other: _____</p>	<p><b>Authorized Disclosure and Delivery Instructions:</b></p> <p>Mail records to address above.</p> <p>Fax records to: _____</p> <p>Call for pickup at: _____</p> <p>Send encrypted email to: _____</p>
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**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 by submitting my request in writing to the Release of Information office. If I have authorized the release 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 of 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 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: \_\_\_\_\_.

**Acknowledgment:** 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.

**For Marketing/Fundraising Purposes only, if applicable:** I understand that FCC \_\_\_\_\_ will \_\_\_\_\_ will not receive remuneration either direct or indirect, as a result of the marketing that I hereby authorize.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
Patient (Parent or Legal Guardian)

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): \_\_\_\_\_ POA \_\_\_\_\_ Death Certificate \_\_\_\_\_

Name of individual signing on behalf of patient: \_\_\_\_\_

Verification of Identity: Driver's License # \_\_\_\_\_ Other ID: \_\_\_\_\_

