



## Patient Authorization to Disclose Protected Health Information

<b>Patient Name</b>	<b>Date of Birth</b>	<b>Last 4 of SSAN</b>
<b>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:</b>		
<b>Release Information to:</b>  _____ Organization, Agency, Individual  _____ Address  _____ City, State, Zip  _____ Phone Number  <b>Information Released by:</b>  _____ Organization, Agency, Individual  _____ Address  _____ City, State, Zip  _____ Phone Number		<b>Protected Health Information Allowed to be included:</b>  <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Treatment Summary <input type="checkbox"/> History and Consults <input type="checkbox"/> Lab Work <input type="checkbox"/> Encounter Notes <input type="checkbox"/> Medication Records <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Other (specify) _____  <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>
<b>Treatment Date(s):</b> _____  <b>Purpose:</b> Care Coordination <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Personal Use <input type="checkbox"/> Insurance <input type="checkbox"/> Legal <input type="checkbox"/> Marketing <input type="checkbox"/> Other: _____		<b>Authorized Disclosure and Delivery Instructions:</b>  <input type="checkbox"/> Mail records to address above. <input type="checkbox"/> Fax records to: _____ <input type="checkbox"/> Call for pickup at: _____ <input type="checkbox"/> Send encrypted email to: _____

**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: \_\_\_\_\_

