Family Care Center
Behavioral Health Services

Patient Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of SSAN

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:

Release Information to:

_____
Organization, Agency, Individual

_____
Address

_____
City, State, Zip

_____
Phone Number

Information Released by:

_____
Organization, Agency, Individual

_____
Address

_____
City, State, Zip

_____
Phone Number

Protected Health Information Allowed to be included:

☐ Discharge Summary
☐ Treatment Summary
☐ History and Consults
☐ Lab Work
☐ Encounter Notes
☐ Medication Records
☐ Entire Medical Record
☐ Other (specify)

***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.**

Treatment Date(s): _____

Purpose:

Care Coordination ☐ Workers' Comp ☐
Personal Use ☐ Insurance ☐
Legal ☐ Marketing ☐
Other: _____

Authorized Disclosure and Delivery Instructions:

☐ Mail records to address above.
☐ Fax records to: _____
☐ Call for pickup at: _____
☐ 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 renumeration 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: _____