



Patient Label

Patient Authorization to Disclose Protected Health Information #CHCR-004 rev. 12/12



AUTHPHI

Patient Authorization to Disclose Protected Health Information

Form with fields: 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.

Form with fields: Release by (Facility, Address, City, State, Zip Code, HIM Phone/Fax Numbers), Release to (Organization, Agency, Individual, Attn, Address, City, State, Zip Code)

Form with sections: Treatment Date(s), Purpose (Further Medical Care, Workers' Comp, Personal Use, Insurance, Legal, Marketing/Fundraising, Other), Type of Disclosure Authorized & Delivery Instructions (Provide copies, Mail records, Call to pick-up records, Fax records)

Form with section: Pertinent Protected Health Information Allowed to be Included (Discharge Summary, History & Physical/Consult, Operative Report, Labs, Radiology, Outpt Record, Progress Notes, Physician Orders, Special Studies, Medication Records, Psych Health 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 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.

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 will or 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): \_\_\_\_\_ Power of Attorney Death Certificate

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

Verification: Drivers License # \_\_\_\_\_ 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: \_\_\_\_\_ / \_\_\_\_\_