



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)

*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.

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.

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: _____ / _____