



# Rocky Mountain OB-GYN

UNIVERSITY OF COLORADO

MRN: \_\_\_\_\_

## Authorization to Disclose Protected Health Information

Patient Name: \_\_\_\_\_ Formerly Known As: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Purpose of Request:  Continuation of Care  Personal  Legal  Insurance  Other: \_\_\_\_\_

I authorize release to: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name/Facility: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Service range (month/year): From: \_\_\_\_\_ To: \_\_\_\_\_

<input type="checkbox"/> Abstract (Physician notes, Lab, Radiology, Cardiology)	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> Billing/UB04	<input type="checkbox"/> Laboratory Results
<input type="checkbox"/> Clinic/Progress Notes	<input type="checkbox"/> <b>Mental Health Treatment*</b>
<input type="checkbox"/> Complete (All records, notes, meds, flowsheets, etc.)	<input type="checkbox"/> Operative Note
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>Drug/Alcohol Treatment*</b>	_____
<input type="checkbox"/> Emergency Room Report	_____
<input type="checkbox"/> Facesheet	<input type="checkbox"/> Radiology Reports
<input type="checkbox"/> <b>Genetic Information*</b>	<input type="checkbox"/> Radiology Images
<input type="checkbox"/> History and Physical	<input type="checkbox"/> <b>Sickle Cell*</b>
<input type="checkbox"/> <b>HIV/AIDS Information*</b>	<input type="checkbox"/> <b>STD/Communicable Disease*</b>

\*I hereby consent to disclose the above bolded/specialized information. \_\_\_\_\_

**Patient's Signature required**

\*\*\*\*\*

1. **Requests will be processed within 10 business days.**
2. I authorize the release of my medical record, including photographs.
3. This authorization is voluntary and the disclosure is made at my request.
4. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. Multiple requests are authorized if the purpose of the request remains the same.
6. I have a right to revoke this authorization at any time and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
7. I need not sign this form to ensure health care treatment.

I request this authorization to expire on \_\_\_\_\_ or 180 days from the date signed below and **covers only treatment for the dates specified above.**

I am also aware fees, outlined below, for copy services may apply. NOTE: Fees/charges will comply with all laws and regulations applicable to the release of information. Standard copying fees are as follows:

**No charge for pages 1-10 .50 cents for each page from 11-40 .33 cents for each additional page**

Additionally, an initial set of radiological films/CD-ROM can be provided at no cost to a patient for physician or facility referral. However, **a fee of \$5.00 per sheet of film and \$7.00 per CD-ROM will be charged for additional copies.**

**IMPORTANT WARNING:** The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is **STRICTLY PROHIBITED.**

Signature of Patient or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

ID:  Driver's License \_\_\_\_\_  State ID \_\_\_\_\_  Military ID \_\_\_\_\_

If signed by legal representative, indicate documentation:  Death Certificate  Power of Attorney  Living Will

Processed by: \_\_\_\_\_ Date: \_\_\_\_\_ Mailed/Faxed/Given by: \_\_\_\_\_