Authorization to Release Protected Health Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information.

Part A: Patient/Individual		
First Name	**Middle Name**	**Last Name**
Date of Birth	**Phone Number**	

Part B: I Authorize the Following to Disclose the Patient/Individual's Protected Health Information		
Person/Organization Name	Phone Number	Fax Number

Part C: Who Can Receive and Use the Health Information?

The people or companies listed and checked below have the right to see my records. (They must be 18 or older).

Write in first and last names.

Part D: Reason for Disclosure (Choose at least one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Insurance
- ☐ School
- ☐ Personal Use
- ☐ Legal Purposes
- ☐ Employment
- ☐ Billing or Claims
- ☐ Disability Determination
- ☐ Other

Part E: My Records

Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. **If all health information is to be released, then check only the first box.**

I will let Colorado Physician Partners share the records below:

☐ All health information. This can be records about your health, a diagnosis (name of illness or health problem), claims, names of doctors, and other health care providers. Records also can be about insurance and billing). Checking this box will not let others see sensitive (very personal) records unless I agree to it below.

OR

Only some records (check all that apply to you)

- ☐ History/Physical Exam
- ☐ Past/Present Medications
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Lab Results
- ☐ Patient Allergies
- ☐ Diagnostic Test Reports
- ☐ EKG/Cardiology Reports
- ☐ Radiology Reports & Images
- ☐ Physician's Orders
- ☐ Operation Reports
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ Other______________________

I also will let Colorado Physician Partners share this type of sensitive (very personal) record(s) below.
Your initials are required to release any of the following information.

_______ All sensitive records below **OR**

Just some records about topics below (your initials are required for each option chosen)

_______ Mental Health Records (excluding psychotherapy notes)
_______ Genetic Information (including Genetic Test Results)
_______ Drug, Alcohol, or Substance Abuse Records
_______ HIV/AIDS Test Results/Treatment

Part F: Effective Time Period (Check Only One Box)

This authorization is valid for one year or until the earlier of the occurrence of: the death of the individual, the individual reaching the age of majority, authorization is withdrawn, or the following specific date (optional):

☐ Month_________ Day_________ Year________ **OR**
☐ Before one year and on the date, event, or reason written here:

Part G: Review and Sign

RIGHT TO REVOKE: I know I may take back that I agreed to this sharing of information at any time by putting in writing that I want to take it back. I know I cannot cancel this signed form after you have given out my health records

RIGHT TO NOT AGREE: I know that I will still receive care even if I do not agree to release my health records.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signature of Individual or Individual's Legally Authorized Representative	**Date**

Printed Name of Legally Authorized Representative (if applicable):

____

If representative, specify relationship to the individual:
☐ Parent of minor
☐ Guardian
☐ Other ________________________________

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care; sexually transmitted diseases; drug, alcohol or substance abuse; and mental health treatment.

Signature of Minor Individual	**Date**

Right to Receive a Copy – The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization after it has been filled out. Please request a copy from your Colorado Physician Partners representative.