uchealth

Authorization to Disclose Protected Health Information

Select the UCHealth facility/group from which you are requesting records:

- ☐ Broomfield Hospital
- ☐ Grandview Hospital
- ☐ Greeley Hospital
- ☐ Highlands Ranch Hospital
- ☐ Longs Peak Hospital
- ☐ Medical Center of the Rockies
- ☐ Memorial Hospital
- ☐ Pikes Peak Regional Hospital
- ☐ Poudre Valley Hospital
- ☐ University of Colorado Hospital
- ☐ Yampa Valley Medical Center
- ☐ UCHealth Medical Group
- ☐ Other Facility/Provider _____

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 _____

Name/Facility _____ Fax _____

Address _____ City/State _____ Zip _____

Date of service range (month/year): From _____ to _____

If released to self, select method of release: ☐ Email _____

☐ My Health Connection ☐ Mail ☐ PowerShare (radiology images only)

- ☐ Billing/UB04
- ☐ Clinic/Progress notes
- ☐ Discharge summary
- ☐ **Drug/Alcohol treatment***
- ☐ Emergency room report
- ☐ Facesheet
- ☐ **Family Planning/Reproductive Health***
- ☐ **Genetic information***
- ☐ History & Physical
- ☐ **HIV/AIDS information***
- ☐ Immunization record
- ☐ Laboratory results
- ☐ **Mental health treatment***
- ☐ Operative note
- ☐ Radiology reports
- ☐ Radiology images
- ☐ **Sickle cell information***
- ☐ **STD/Communicable diseases***
- ☐ Visit record (includes emergency room records, provider notes/reports, Health data, medical history, medicine and allergy lists, test results; does not include images)
- ☐ Visit summary (includes provider notes/reports, test results; does not include images)

☐ Other _____

***I hereby consent to disclose the above bolded specialized information.** _____

Patient's signature is required.

1. I authorize the release of my medical record, including photographs.
2. This authorization is voluntary and the disclosure is made at my request.
3. 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.
4. Multiple requests are authorized if the purpose of the request remains the same.
5. 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.
6. 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 date(s) specified above**.

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

To patient: $6.50 all pages (CD or electronic delivery). My Health Connection delivery is free (all pages).
Paper delivery: 1-10 are free, 11-99 pages are $6.50, 100 or more pages delivered electronically only.

To third party recipient: $18.53 (retrieval fee for pages 1-10) **plus** $0.85 (each pages 11–40) **plus** $0.57 (each page over 40)

Additionally, an initial set of radiological films/CD-ROM can be provided at no cost to a patient for physician or facility referral.

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

FOR HIM OFFICE USE ONLY

MRN _____ CSN/FIN _____

ID: ☐ Driver's license _____ ☐ State ID _____ ☐ Military ID _____

If signed by a legal representative, indicate documentation: ☐ Death certificate ☐ Power of attorney ☐ Living Will

Processed by _____ Date _____ Mailed/faxed/given by _____