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
- ☐ Parkview Medical Center
- ☐ Parkview Pueblo West
- ☐ Pikes Peak Regional Hospital
- ☐ Poudre Valley Hospital
- ☐ University of Colorado Hospital
- ☐ Yampa Valley Medical Center
- ☐ Other Facility/Provider

Name _____
Address _____
_____
Phone _____
Fax _____

Patient name _____ Formerly known as _____ Date of Birth _____

Address _____ City/State _____ Zip _____ Phone _____

Purpose of Request: ☐ Continuation of care ☐ Personal ☐ Legal ☐ Insurance ☐ Other _____

I authorize release to (Name/Facility) _____

Phone _____ 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
- ☐ **Pathology Reports**
- ☐ **Pathology Slides**
- ☐ **Procedure Reports**
- ☐ Radiology reports
- ☐ Radiology images
- ☐ **Sickle cell information***
- ☐ **STD/Communicable diseases***
- ☐ Transplant Evaluation documentation, including Selection Committee Notes
- ☐ 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 _____

Note: Additional authorization/documentation may be required for deceased patient, behavioral health, or drug/alcohol treatment records.

***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. 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.
5. I need not sign this form to ensure health care treatment.
6. I understand that I may be authorizing release of reproductive healthcare information that may be used in pursuit of litigation against me.

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: My Health Connection delivery is free. Paper: 1-100 pages – free; 100+ pages will be sent electronically. Radiology images: 1st disc is free; Additional discs are $6.50 each.

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)

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed and may contain information that is privileged and confidential. This disclosure 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 _____