



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

- Selection checkboxes for various UCHealth facilities: Broomfield Hospital, Memorial Hospital, Other Facility/Provider, Estes Valley Medical Center, Parkview Medical Center, Grandview Hospital, Parkview Pueblo West, Greeley Hospital, Pikes Peak Regional Hospital, Highlands Ranch Hospital, Poudre Valley Hospital, Longs Peak Hospital, University of Colorado Hospital, Medical Center of the Rockies, Yampa Valley Medical Center.

Authorization to Disclose Protected Health Information

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)

- Checkboxes for various medical records: 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, Visit record, Visit summary.

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.
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

