NORTHWEST COLORADO HEALTH

# Authorization for Use or Disclosure of Protected Health Information

Name of Patient _____

Date of Birth _____ SS# _____ Contact Phone # _____

Address _____

**Request Information FROM:**

Name _____

Phone # _____ Fax # _____

Address _____

**Release Information TO:**

Name _____

Phone # _____ Fax # _____

Address _____

## Information to be released:

From & To Dates _____

- ☐ History and Physical Exam _____
- ☐ Lab Report _____
- ☐ X-Ray Report _____
- ☐ Consultation Report _____
- ☐ Other _____

## Purpose of Disclosure:

- ☐ History and Physical Exam
- ☐ Lab Report
- ☐ X-Ray Report
- ☐ Consultation Report
- ☐ Other _____
- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ☐ Substance Abuse (including alcohol/drug abuse)
- ☐ Mental Health
- ☐ Psychotherapy Notes
- ☐ HIV related information (including AIDS related testing)

The confidentiality of these records is required Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in this statute.

**X** _____

**Signature of Parent or Legal Guardian** **Date**

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Northwest Colorado Visiting Nurse Association / Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.

   **Northwest Colorado Health**
   **Attn: Privacy Officer**
   **940 Central Park Drive, Suite 101**
   **Steamboat Springs, CO 80487**
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS – related information, and psychiatric/ mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I hereby authorize Northwest Colorado Health to use or disclose my protected health information as indicated. I understand that by my request, I will receive a copy of this form after I sign it.

**By signing below, I acknowledge that I have read and understand this Authorization.**

_____ **OR** _____

**Signature of Patient** **Date** **Parent/Legal Guardian/Authorized Person** **Date**

_____ _____

**Records Received By** **Date** **Relationship to Patient**

*Original Date of Form: Effective Date April 14, 2003* *2nd Revised Date: December, 2014* *3rd Revised Date: January 7, 2016*