NORTHWEST COLORADO HEALTH

Authorization for Use or Disclosure of Protected Health Information

Medical and/or Dental

We value your privacy at Northwest Colorado Health. Legally, we cannot release your written health record to anyone (including you) without your specific consent. We need every question on this form answered in order to share your information. We will work on your request as soon as possible, but it may take up to 48 business hours to complete.

About You

Patient Information:

Patient Name: _____ Date of Birth: _____ SS# _____

Address: _____ Phone # _____

Your Medical Records

Request Information FROM: *Please populate all known information* ☐ **Northwest Colorado Health**

Name / Agency _____

Phone # _____ Fax # _____

Address _____ City/State _____

Release Information TO: *Please provide all known information*

☐ **Self / Legal Guardian** ☐ **Northwest Colorado Health** ☐ **Other**

Name _____

Phone # _____ Fax # _____

Address _____

Information to be released: ☐ **MEDICAL** ☐ **DENTAL**

From & To Dates: _____

- ☐ ALL Dates
- ☐ Progress Note _____
- ☐ Lab Report _____
- ☐ X-Ray Report _____
- ☐ Other _____

Purpose of Disclosure:

- ☐ Second Opinion
- ☐ Legal
- ☐ Insurance
- ☐ School
- ☐ Primary Care Provider Change
- ☐ Other: _____

Special Situations

I understand that this health information may include HIV-related information 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) ☐ HIV related information (including AIDS related testing)

I understand that if I also saw a Behavioral Health Provider for Substance Abuse a second release is required to be completed for those records.

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 Patient, Parent or Legal Guardian **Date**

Signature

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.

_____ _____

Signature of Patient **Date** **Records Received By** **Date**

_____

Relationship to Patient if not self

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