

Patient's name \_\_\_\_\_ DOB \_\_\_\_\_

 Release from  Release to

- |   |   |
|---|---|
| <input type="checkbox"/> BOULDER COMMUNITY HOSPITAL, P.O. Box 9019, North Broadway & Balsam, Boulder, CO 80301-9019 | <input type="checkbox"/> MEDICAL IMAGING CENTER |
| <input type="checkbox"/> FOOTHILLS HOSPITAL, P.O. Box 9047, 4747 Arapahoe Avenue, Boulder, CO 80301                 | 36 Garden Center                                |
| <input type="checkbox"/> MAPLETON CENTER, P.O. Box 9130, 311 Mapleton Avenue, Boulder, CO 80301-9130                | Broomfield, CO 80020                            |
| <input type="checkbox"/> COMMUNITY MEDICAL CENTER, 1000 W. South Boulder Road, Lafayette, CO 80026                  |   |
| <input type="checkbox"/> BOULDER COMMUNITY HOSPITAL, IMAGING, 2750 Broadway, Boulder, CO 80304                      |   |
| <input type="checkbox"/> OTHER _____  |   |
| <input type="checkbox"/> Attn: Person or Program _____  |   |

 Release from  Release to \_\_\_\_\_

**GENERAL AUTHORIZATION:** I authorize the above-named health care provider to release the information specified below to the organization/ agency/individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication by appropriate practitioner.

I understand that BCH may not refuse to provide treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the purpose of the treatment is to provide information to the party listed in this authorization. I understand that except for drug and alcohol treatment records, information disclosed under this authorization may be redisclosed by the recipient and is no longer protected by privacy laws.

**SPECIFIC AUTHORIZATION:** I specifically authorize the release of information regarding the following conditions:

- Alcohol / Drug abuse information – I understand that my chemical dependency records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CRF, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (See reverse side for redisclosure prohibition)
- Psychosocial / Psychiatric information (excludes psychotherapy notes which require separate release)
- Other \_\_\_\_\_

**INFORMATION REQUESTED:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Complete copy of medical record  | <input type="checkbox"/> Operative reports, consults         | <input type="checkbox"/> Nurses' notes  |
| <input type="checkbox"/> History and physical exam        | <input type="checkbox"/> Laboratory reports                  | <input type="checkbox"/> Therapy notes & dictation  |
| <input type="checkbox"/> Discharge summary                | <input type="checkbox"/> Imaging reports                     | <input type="checkbox"/> Psychological eval. (excludes psychotherapy notes)                                     |
| <input type="checkbox"/> Treatment plan                   | <input type="checkbox"/> EKG                                 | <input type="checkbox"/> Neuropsych / Psych. testing & evals (does not include raw data or psychotherapy notes) |
| <input type="checkbox"/> Admitting Psychiatric Assessment | <input type="checkbox"/> EEG                                 |   |
| <input type="checkbox"/> Emergency Department record      | <input type="checkbox"/> Physician's orders & progress notes |   |
| <input type="checkbox"/> Other: _____                     |  |   |

**CONDITIONS AND DATES OF CARE COVERED:**

- Regarding these treatment dates and/or for conditions: \_\_\_\_\_
- All admissions or care at this facility provided as of the date of my signature.

**PURPOSE(S) FOR WHICH INFORMATION IS TO BE USED:**

- Further eval / treatment
- Insurance / reimbursement
- Legal
- Verify Treatment Status
- Personal use
- Worker's Compensation
- Other (specify) \_\_\_\_\_

**EXPIRATION OR REVOCATION OF AUTHORIZATION**

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous expressed revocation, this authorization will automatically expire 90 days from the date of my signature unless noted below.

- On \_\_\_\_\_  No longer than \_\_\_\_\_ days from the date of my signature or under the following conditions: \_\_\_\_\_
- Upon fulfilling the purpose or need for information as specified above, but no longer than \_\_\_\_\_ days from the date of my signature.

**NOTE:** Federal regulations require consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.

**SIGNATURE :** A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Authorized representative name (please print) \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Authorized representative signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_



ROI

 DOB: \_\_\_\_\_ /  
 ACCT NO: \_\_\_\_\_ MR:  
 < Place Label Here >  
 ATTEND DR: \_\_\_\_\_

**HIPAA Release of Medical Information**

In accordance with 42 C.F.R. Section 2.13, any disclosure of information from a federally assisted drug or alcohol abuse program must be limited to that information which is necessary to carry out the purpose of the disclosure.

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Pursuant to 42 C.F.R. Section 2.32, the following statement on the prohibition of redisclosure must accompany each disclosure made with the patient's written consent:

**PROHIBITION ON REDISCLOSURE**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**HIPAA  
Release of Medical Information**



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