Boulder Community Health

Patient Information

Full Name _____ Date of Birth _____

Maiden or Other Names Used _____ Social Security Number: XXX-XX- _____ (last 4 digits)

Address _____

Phone # _____ City _____ State _____ Zip _____

Release Information From

Hospital/Clinic Name: _____

Address _____

Phone # _____ FAX # _____ City _____ State _____ Zip _____

Release To

Recipient Name: _____

Address: _____

Phone # _____ FAX # _____ City _____ State _____ Zip _____

Purpose

❑ Continuation of Care ❑ Insurance/WC ❑ Legal

❑ Personal ❑ Other (Specify_____)

Date(s) of Information to be Released

Date(s) of Service From _____ through _____

Information to be Released/Accessed

I would like copies of the items checked below for the treatment dates listed above.

ONLY the following:

❑ Emergency Report ❑ Discharge Summary ❑ History & Physical ❑ Imaging CD/Film: (MRI/CT/X-Ray/Ultrasound)

❑ Operative Report ❑ Consultation ❑ Laboratory

❑ Clinic Visit ❑ Billing Records ❑ Cardiac Studies/EKG ❑ Imaging Report

❑ Entire medical record (Legal medical record) ❑ Other: _____

❑ Pertinent medical record-**(Default for patient requests:** Discharge Summary, H&P, Operative Report, Emergency Report, Consultation)

➢ **I understand the following information will be disclosed unless I indicate otherwise, checking the box means I do <u>NOT</u> authorize disclosure of the following information:** ❑ Genetic Testing ❑ HIV ❑ Behavioral Health ❑ Substance Use Disorder Treatment

Disclosure/Access Format

I would like copies of the items checked above in the following format: (Paper format-US Mail is default if not marked)

❑ Paper Format- US Mail ❑ CD ❑ USB ❑ Fax (Healthcare Provide ONLY) ❑ Other: _____

❑ Paper Format-Pick-Up ❑ Review Only ❑ Encrypted Email to: _____

I Understand That

Without my express revocation, this authorization will automatically expire 180 days from the date signed below, unless a different event is specified here: _____

I understand I may revoke this authorization in writing at any time by submitting the revocation request to the Health Information Management Department or via email to HIM@BCH.org, except to the extent that action has already been taken to comply withit. Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer protected by applicable federal or statelaw. I understand if this authorization is signed for purposes of Substance Use Disorder alignment with HIPAA Treatment,Payment and Health care operations uses and disclosures, information may be re-disclosed in accordance with HIPAA, except for uses and disclosures forcivil, criminal, administrative and legislative proceedings against the patient. I understand that BCH may not refuse treatment if I refuse to sign thisauthorization, unless this authorization is necessary to participate in a research study, to receive Substance Use Disorder Treatment or if the treatment provided is to be solely for the purpose of creating protected health information for disclosure to the party listed in this authorization. Treatment,Payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization. I understand that if I am asked to sign thisauthorization, I have a right to receive a copy of the authorization and I have been provided the opportunity to receive a copy. I have also been informed that this signed authorization is also available in the patient portal.

_____ _____ _____

Signature of Patient/Guardian/Personal Representative **Relationship** **Date**

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law

_____

Personal Representative's PRINTED Name, Address, and Phone Number