Highlands Family Medicine

Authorization to Disclose Health Information

1. I authorize the disclosure of health information of the individual named below:

Patient name: ______________________________ Previous name: ______________________

Address: ____

Phone #: ________________ Date of Birth: _____/_____/_____ SSN: __________________

Medical facility that records are requested FROM: To be disclosed TO:

(Name)__________________________________ ____________________________________

(Phone/fax)______________________________ ____________________________________

(Address)________________________________ ____________________________________

____ ____________________________________

2. The type and amount of information to be disclosed is as follows (specify dates where appropriate):

☐ My health information relating to the following treatment or condition: __________________ _________

☐ Most recent 3 years of record ☐ My health information for the date(s): ______________

☐ Entire medical record *(Circle "Include" or "Exclude")*

Include / Exclude: My health information related to drug and/or alcohol abuse

Include / Exclude: My health information related to HIV/AIDS

Include / Exclude: My health information related to psychological or psychiatric conditions

☐ Other: ____

3. Purpose: ☐ Continuation of treatment ☐ Other __________________________________

4. I understand that this authorization will expire, without my express revocation, either one year from the date of signing, or, if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

5. I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

6. I understand that there may be a fee involved with the fulfillment of this request in accordance with Colorado Law Regulations for Patient Medical Reproduction Fee 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4., which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient records, not to exceed $14.00 for the First 10 pages, $.50 per page for pages 11-40 and $.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax if any may be charged.

____ ______________________________

Signature of Patient or Authorized Personal Representative Date

____ ______________________________

Personal Representative's Name (print) Relationship (parent, legal guardian, personal representative, etc.)