University of Colorado Colorado Springs

Patient Name(s) ____________________

Medical Record # ____________________

Date of Birth ____________________

Contact Phone # ____________________

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

☐ Obtain From: (Releasing facility)

tŀĞĂƐĞ ĐŚĞĐŬ ŽŶĞ ŽĨ ƚŚĞ ĨŽůůŽǁŝŶŐ /ůŝŶŝĐƐ Žƌ ĨŝůůŝŶ ŝŶĨŽƌŵĂƚŝŽŶ ĨŽƌ ĂŶ ŽƵƚƐŝĚĞ ĨĂĐŝůŝƚǇ

☐ Aging Center (719) 255-8002 (719) 255- 8006 Fax	☐ CĂŵŝůǇ ĂŶĚ ŚŝůĚ ŝŶŝĐ (719) 255- 80ст (719) 255- 8044 Fax
☐ Peak Nutrition Clinic (719) 255- 7524 (719) 255- 8044 Fax	☐ Nurse-Family Partnership© (719) 255-8044
☐ Veterans Health ϑ Trauma (719) 255- 8003 (719) 255- 8075 Fax	☐ Primary Care Clinic (719) 255- 8001 (719) 255- 8044 Fax

tŚǇƐŝĐŝĂŶ Name:______________________________

____

Address: ______________________________

/ity, State, Zip: ______________________________

Phone:________________ Fax: ________________

Purpose:

- ☐ Continuity of Care
- ☐ Personal Use
- ☐ Legal
- ☐ Coordination of Care
- ☐ Other ______________________

INFORMATION TO BE OBTAINED (ĐŚĞĐŬ Ăůů ƚŚĂƚ ĂƉƉůǇ)

Date of Service Range (month/year):

From: ________ To: ________

☐ ŝĂŐŶŽƐƚŝĐ ^ƚƵĚŝĞƐ	☐ ŝƐĐŚĂƌŐĞ ^ƵŵŵĂƌǇ
☐ ,ŝƐƚŽƌǇ ϑ WŚǇƐŝĐĂů	☐ >ĂďŽƌĂƚŽƌǇ ZĞƉŽƌƚƐ
☐ /ůŝŶŝĐ WƌŽŐƌĞƐƐ EŽƚĞƐ	☐ Radiology /ŵĂŐĞƐ
☐ DĞŶƚĂů ,ĞĂůƚŚ ^ƵŵŵĂƌǇ	☐ KƚŚĞƌ ______________

☐ Release To: (Receiving facility)

tŀĞĂƐĞ ĐŚĞĐŬ ŽŶĞ ŽĨ ƚŚĞ ĨŽůůŽǁŝŶŐ /ůŝŶŝĐƐ Žƌ ĨŝůůŝŶ ŝŶĨŽƌŵĂƚŝŽŶ ĨŽƌ ĂŶ ŽƵƚƐŝĚĞ ĨĂĐŝůŝƚǇ

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tŚǇƐŝĐŝĂŶ Name:______________________________

____

Address: ______________________________

/ity, State, Zip: ______________________________

Phone: ________________ Fax: ________________

Purpose:

- ☐ Continuity of Care
- ☐ Personal Use
- ☐ Legal
- ☐ Coordination of Care
- ☐ Other ______________________

INFORMATION TO BE RELEASED (ĐŚĞĐŬ Ăůů ƚŚĂƚ ĂƉƉůǇ)

Date of Service Range (month/year):

From: ________ To: ________

☐ ŝĂŐŶŽƐƚŝĐ ^ƚƵĚŝĞƐ	☐ ŝƐĐŚĂƌŐĞ ^ƵŵŵĂƌǇ
☐ ,ŝƐƚŽƌǇ ϑ WŚǇƐŝĐĂů	☐ >ĂďŽƌĂƚŽƌǇ ZĞƉŽƌƚƐ
☐ /ůŝŶŝĐ WƌŽŐƌĞƐƐ EŽƚĞƐ	☐ Radiology /ŵĂŐĞƐ
☐ DĞŶƚĂů ,ĞĂůƚŚ ^ƵŵŵĂƌǇ	☐ KƚŚĞƌ ______________

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, and further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and **THERE MAY BE A COST TO COPY THE RECORDS OR WRITE A TREATMENT SUMMARY.**

I understand there are limited exceptions to these provisions in the Colorado Statutes. These require reporting of threats of violence, harm, or child or elder abuse and neglect (from either evidence or suspicion), or when subpoenaed by the courts, to proper authorities. Certain other exceptions exist and will be explained as necessary.

I understand that **this consent expires the sooner of one year from the date of my signature or 6 months from the last appointment** unless otherwise specified as follows: _____ I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date of this authorization. A copy, fax, or scan of this form is to be considered as valid as the original.

_____ _____

Signature of Patient or Authorized Representative **Date of Signature**

_____ _____

Printed Name **Relationship to Patient (if applicable)**

(Please Provide a Copy of This Form to the Patient)

Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated above:

_____ _____

Signature of Patient or Personal Representative Date