# ALL FIELDS WITH A * ARE REQUIRED

University of Colorado
Colorado Springs

***Patient Name(s):**

***Date of Birth:**

***Contact Phone #:**

## AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

***Choose one below:**

| ☐ **Obtain From: (Releasing facility)** | ☐ **Release To: (Receiving entity)** |
|---|---|

**UCCS HealthCircle Primary Care Clinic:**
**4863 N Nevada Ave, Colorado Springs, CO 80918**
**Phone: 719-255-8001 Fax: 719-255-8044**

***Choose one below:**

| ☐ **Obtain From: (Releasing facility)** | ☐ **Release To: (Receiving entity)** |
|---|---|

*Provider Name:_____________________________________________

*Address:__________________________________________________

*City, State, Zip____________________________________________

*Phone:___________________________________________________

*Fax:_____________________________________________________

***The Purpose for this Release:**

- ☐ Continuity of Care
- ☐ Damage/Claim Information
- ☐ Personal Use
- ☐ Legal
- ☐ Coordination of Care
- ☐ Other ________________________

***INFORMATION TO BE RELEASED AND / OR OBTAINED (CHECK ALL THAT APPLY):**

| | | |
|---|---|---|
| ☐ Emergency Room Report | ☐ Mental Health Treatment | ☐ Genetic Information |
| ☐ Discharge Summary | ☐ Drug/Alcohol Treatment | ☐ HIV/AIDS Information |
| ☐ Operative Report | ☐ Radiology Reports | ☐ Radiology Images |
| ☐ History and Physical | ☐ Laboratory Reports | ☐ Other: ________________ |
| ☐ Clinic/Progress Notes | ☐ Immunization Records | ______________________ |

*Date of Service Range (month/year): *From:________________ *To:______________________

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**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)**

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## Revocation of Authorization to Release Information

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

| ______________________________ | ______________________________ |
|---|---|
| Signature of Patient or Personal Representative | Date |