SOUTH DENVER CARDIOLOGY

SOUTH DENVER CARDIOLOGY ASSOCIATES
PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth	Last 4 Digits of Social Security Number
Address	City, State, Zip Code	Telephone Number

I hereby authorize the facility listed below so disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release by: _____
Facility

_____
Address

_____
City, State, Zip Code

Release to: _____
Organization, Agency, Individual

_____
Attn:

_____
Address, City, State, Zip Code

Treatment Date(s): _____

Purpose (check all that apply):
☐Further Medical Care ☐Legal ☐Workers' Comp
☐Insurance ☐Personal Use ☐ Marketing/Fundraising
☐Other _____

Type of Disclosure Authorized & Delivery Instructions:
☐ Provide copies of records to organization/agency/individual
☐ Mail records directly to address above
☐ Call to pick-up records: _____
☐ Fax records to: _____

Pertinent Protected Health Information Allowed to be Included (check all that apply):
☐Discharge Summary ☐Radiology ☐Special Studies ☐Entire Medical Record
☐H&P/Consult ☐Outpt Record ☐Medication Records ☐Psych Health Reports
☐Operative Report ☐Progress Notes ☐Labs ☐Physician Orders
☐Other (specify): _____

Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information.
A Patient Authorization to Disclose Psychotherapy Notes must be completed.

Authorization: I certify that this request is made voluntarily, and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management/Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility & Privacy Officer.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified here: _____.

Acknowledgement: I understand that the information to be disclosed may include any and all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

For Marketing/Fundraising Purposes Only, if applicable: I understand that Centura Health will __ will not __ receive remuneration, either direct or indirect, as a result of the marketing that I hereby authorize.

SIGNATURE: _____ **DATE:** _____
Patient (Parent or Legal Guardian)
Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado law.
Relationship (if other than patient): _____ Power of Attorney____ Death Certificate ____
Name of individual signing on behalf of patient: _____
Verification: ____ Drivers License # _____ ____ Other Appropriate ID: _____

OFFICE USE ONLY: Attach copies of required identification.
Number of pages released: _____ Completion date: _____ Delivery method: _____
Name of individual who received request: _____ Date received: _____
Patient Medical Record Number/Account Number: _____/_____