Print Clear

Patient Information

Full Name _____ Date of Birth _____

Maiden or Other Names Used _____ SSN: xxx-xx-_____ (last 4 digits)

Address _____

Day Phone _____ Cell Phone _____ City State Zip

Release From

☐ Lutheran Medical Center ☐ Good Samaritan Medical Center ☐ St. Mary's Medical Center ☐ St. James Healthcare
☐ St. Joseph Hospital ☐ Platte Valley Medical Center ☐ St. Vincent Healthcare ☐ Holy Rosary Healthcare
☐ West Pines ☐ Clinic/Doctor, specify: _____

Release To

Person/Company/Organization Name _____

Address _____

Phone _____ Fax _____ City State Zip

Purpose

☐ Continuation of Care ☐ Insurance/WC ☐ Legal
☐ Personal ☐ Other (specify) _____

Date(s) Of Information To Be Disclosed

Date(s) of Service from _____ through _____
Date(s) of Service from _____ through _____

Information To Be Disclosed I would like copies of the items checked below for the above treatment dates.

☐ Emergency Report ☐ Discharge Summary ☐ History & Physical ☐ Imaging CD/Film (MRI/CT/X-Ray/Ultrasound)
☐ Operative Report ☐ Consultation ☐ Laboratory ☐ Imaging Report
☐ Clinic Visit ☐ Billing Record ☐ Cardiac Studies/EKG ☐ Other _____

Disclosure Format I would like copies of the items checked above in the following format (Paper–US Mail is default if not marked).

☐ Paper – US Mail ☐ CD ☐ Fax (healthcare provider only)
☐ Paper – pick up ☐ Review only ☐ Email to _____

Patient Access Information

- I will provide a picture ID prior to accessing my medical record.
- I may review my medical record without a charge. If I request copies of my medical record, I may be charged a fee.
- I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.
- A Care Site professional will supervise the review of my medical record.
- If I am involved in a research study involving medical treatment, my access to the research study content may be suspended for as long as the research is in progress. At the completion of the research, access to my medical record will be reinstated.

I Understand That

- The information to be disclosed may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.
- Without my express revocation, this authorization will automatically **expire** 180 days from the date signed below, unless I request an expiration date less than 180 days.
- I may **revoke** this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule, unless the disclosure includes records from a federally-assisted program specifically providing diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case **redisclosure is prohibited** under 42 CFR Part 2.

My signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided. According to State Statutes, this Care Site may charge for copies of medical records.

_____

Signature of Patient/Guardian/Personal Representative Relationship (if not patient) Date

_____

Personal Representative's **Printed** Name, Address, Phone

If patient is unable to sign, document reason: _____

Return completed form to:	• Email: peaks_croi@imail.org • Fax: 303-467-8966 • Mail: Centralized Release of Information, 15755 E 32nd Avenue, Suite 1A, Aurora, CO 80011

For Office Use Only

Date Authorization Received: _____ By: _____ Identification/Driver License Verified: _____

Date Request Completed: _____ By: _____ Delivery Instructions: _____

SCL Health

Authorization for Disclosure of Protected Health Information (PHI)

A-MR-0215-1122

PATIENT INFORMATION

Place label here.
Scanning does NOT work if label is outside this guide.