ESTES PARK
HEALTH

Estes Park Health, 555 Prospect Ave, Estes Park, CO 80517

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AUTHORIZATION FOR DISCLOSURE OF PHI

Estes Park Health is requesting your authorization to Use or Disclose your health information. The following is information about the health information at issue, to whom it will be Disclosed, how we will otherwise Use or Disclose your health information if you sign this form and your rights with regard to this Authorization.

DATE_____ **PATIENT NAME:** _____ **DATE OF BIRTH:**_____

I am the ____Patient____Guardian____Conservator____Designee ____ Surrogate decision maker with authority to use and disclose PHI. _____ Patient's Designated Representative, and I hereby authorize Estes Park Health to disclose to (name and address of person, organization, or agency):

Name of organization/person releasing records to: _____

Phone: _____ Fax: _____

Address: _____ State: _____ Zip:_____

This authorization is valid for a period of one year and can be revoked by me at any time before then. I understand that the request for revocation must be in writing and is effective when received by the Health Information Management Department at EPH. **Exceptions to Right of Revocation:** I understand that my written revocation will not affect the ability of EPH to continue to Use or Disclose my health information to the extent that it has already acted in reliance on this Authorization. For example, EPH cannot rescind disclosures it has already made, and may Use my health information as necessary to bill and collect for services rendered. **Prohibition on conditioning of authorization:** EPH cannot condition treatment on your signing this authorization, unless: You are receiving research-related treatment; or the only reason EPH is providing you with health care is to make a report to a third party, such as your employer.
Date(s) of service to be released:_____.

Please mark information to be released:

____	Clinic Notes	____	Immunization Records
____	History and Physical	____	Laboratory Results
____	Emergency Department Record	____	Problem List/Treatment Plan
____	X-Ray Reports	____	Medication List/Active
____	Other, please specify _____		

It is the policy of Estes Park Health to require a current specific authorization to release the types of information listed below. As a result, if such information is contained in this patient's records that information has not been released to you at this time unless authorized below. Alcohol/Drug treatment records are protected by federal regulation 42 CFR, part 2 and must be specifically authorized by either the patient or his/her representative.

SPECIFIC AUTHORIZATION: Mental Health Information ___ Drug/Alcohol Information ___ AIDS/HIV Testing ___

I understand that upon release of this information, EPH will no longer guarantee the confidentiality of the information contained in my medical record. I release the EPH, the attending physician, and all hospital personnel from any and all liability concerning the release of this information.

I understand that this original form will become a permanent part of my EPH medical record. I also understand that a copy of this form may be mailed or faxed to the entity named above for the release of medical records to EPH.

_____ _____ _____ _____
Patient Signature Date Legal Decision Maker Signature Date

_____ _____
Witness Signature Date

Copied information delivered by means of: _____ hand delivery _____mailed _____faxed _____

NOTE: EPH has a minimum charge of $16.50 for the first 10 pages copied plus $0.75 per page for pages 11-40 and $0.50 for each additional copy thereafter. There will be no charge for information sent from EPH to an insurance company for billing purposes. There will be no charge for information sent to a physician's office unless it exceeds 75 pages.