ESTES PARK
HEALTH

AGREEMENT/ RESTRICTION

RELEASE OF PATIENT HEALTH INFORMATION CONSENT FORM

Release Information To: _____

Address: _____

Reason for Release: _____

_____ I hereby authorize Park Hospital District DBA/ Estes Park Health to share all protected health information concerning my illness or injury with the above-named individual/s.

_____ I hereby deny permission for Park Hospital District DBA/ Estes Park Health to share any protected health information concerning my illness or injury with the above named individual/s.

Signature of Patient: _____ Date: _____

Signature of Witness to Verbal Objection: _____ Date: _____

*PHIAGR

PATIENT LABEL

Estes Park Health
555 Prospect Avenue, PO Box 2740
Estes Park, CO 80517
PHONE 970/586-2317 ● FAX 970/586-0109

6/2018

Updated 6/18

ESTES PARK
HEALTH

(Original to be placed in patient's medical record)

*PHIAGR

PATIENT LABEL

Estes Park Health
555 Prospect Avenue, PO Box 2740
Estes Park, CO 80517
PHONE 970/586-2317 ● FAX 970/586-0109

6/2018