AUTHORIZATION FOR DISCLOSURE OF PHI

555 Prospect Ave., Estes Park, CO 80517 Phone # 970-586-2317 Ext.2030 Fax # 970-586-8237 Email: medrecs@eph.org

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 regarding this authorization.

Patient Name: _____ Date of Birth: _____ Last 4 of SS#: _____
Address: _____ City/State/Zip Code: _____ Telephone #: _____

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 of organization/person receiving records: _____

Address: _____ Phone: _____
City/State/Zip: _____ Fax: _____

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 Medical Record 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. I understand that authorizing disclosure of my health information is voluntary. EPH cannot condition treatment, payment, enrollment or eligibility 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: _____

Purpose:
_____ Further Medical Care ____ Legal
_____ Insurance

Delivery Method:
____ Personal Pickup
___ Email (encrypted)_____

Other, please specify _____

Please mark information to be released:

____ History and Physical	____ Immunization Records	____ Problem List/Treatment Plan
____ Clinic Notes	____ Consultation	____ Medication List/Active
____ Laboratory Results	____ X-Ray Reports	____ Pathology Results

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 representative. Please mark information to be released:
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 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 and 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's Signature Date Legal Decision Maker Signature Date

The state of Colorado allows 10 business days for release request processing

Office Use Only:

Copied information delivered by means of: _____ hand delivery _____mailed _____faxed _____ _____
(initial) (date)

If signed by legal representative, indicate documentation: ☐ Death Certificate ☐ Power of Attorney ☐ Living Will

Note: EPH has a minimum charge of $16.50 for the first 10 pages copied plus $0.75 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. Name of Form: Authorization of Disclosure of PHI, 45 C.F.R. § 164.510