

Patient Information:	Patient Legal Name _____ Birthdate _____ SS# _____		
	Address/City/State/Zip _____		
	Telephone number: _____ Unit Number: _____		
Release From:	I hereby authorize: <input type="checkbox"/> The Medical Center of Aurora <input type="checkbox"/> Centennial Medical Plaza <input type="checkbox"/> Presbyterian/St. Luke's Med Center <input type="checkbox"/> Spalding Rehabilitation Hospital <input type="checkbox"/> HealthONE Clinic Services	<input type="checkbox"/> Rose Medical Center <input type="checkbox"/> North Suburban Med Center <input type="checkbox"/> Sky Ridge Medical Center <input type="checkbox"/> Swedish Medical Center <input type="checkbox"/> Swedish SW ER	Release To:
	Name / Title / Organization _____		
	Address/City/State/Zip _____		
	Telephone# _____ Fax# _____		
Purpose:	<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Insurance or Worker's Comp <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use <input type="checkbox"/> Other _____ For treatment date(s): _____		
Access Requested:	<input type="checkbox"/> Copies of the record <input type="checkbox"/> Inspection of the record	Partinent Info:	<input type="checkbox"/> D/C Summary 9 H&P <input type="checkbox"/> Consult/Operative Report <input type="checkbox"/> Lab/Radiology <input type="checkbox"/> Emergency Room Record
Selected Portions:	<input type="checkbox"/> Outpatient Visit <input type="checkbox"/> Behavioral Health Record <input type="checkbox"/> Special Studies <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Physician Orders <input type="checkbox"/> Billing Record <input type="checkbox"/> Medication Record <input type="checkbox"/> Other _____		
Patient Authorization:	ACKNOWLEDGEMENT: I request and authorize the above-named health care provider to release the information specified above to the organization or individual named on this request. I understand that the information to be released may include information regarding the following condition(s): Sickle Cell Anemia; Genetic testing; Human Immunodeficiency Virus (HIV); Drug Abuse, Alcoholism, Alcohol Abuse, if any; Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any		
	I understand that: 1. My signature on this form is strictly voluntary. 2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy of Practices. 3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. 4. Fees/charges will comply with all laws and regulations applicable to release of information.		
Fees:	Note: HealthONE may charge a fee for copies of the medical records in accordance to Colorado State Law.		
Phys Concurrence, If Applicable:	PHYSICIAN CONCURRENCE FOR PATIENT ACCESS: _____ has my permission to (<i>inspect</i>) (<i>receive copies of</i>) the requested medical records. I have reviewed the medical record(s) and have determined they (<i>do</i>) (<i>do not</i>) contain information relative to psychological or psychiatric problems, which, if revealed to the patient, would be reasonably likely to endanger the life or physical safety of the patient or another person. (If the patient has requested psychotherapy notes, such disclosure (<i>would</i>) (<i>would not</i>) have significant negative psychological impact upon the patient.) Attending physician or designee: _____ Date: _____		
Delivery Instructions:	<input type="checkbox"/> Call requestor for pick-up when records are ready. <input type="checkbox"/> Mail records directly to person or organization specified.	Confirmation of PICK-UP	
	<input type="checkbox"/> I authorize _____ to pick up my Protected Health Information (PHI). (Print Name) _____ Relationship _____	Signature _____ Date _____	
Signature:	My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.		
	Date _____	Patient or Authorized Representative _____	Relationship to Patient _____
	A copy is provided after signature.		
EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified as follows: _____			
OTHER CONDITIONS: A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.			



Authorization for Use and Disclosure of Protected Health Information (PHI)

HealthONE USE ONLY

Verification:

Date Authorization Received: _____ By: _____

Date Request Completed: _____ By: _____

Identification/Driver's License # Verified: _____

Power of Attorney Other _____