University of Colorado Colorado Springs

Patient Name(s) ____________________

Medical Record # ____________________

Date of Birth ____________________

Contact Phone # ____________________

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

☐ Obtain From: (Releasing facility)

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☐ Aging Center (719) 255-8002 ό719) 255- 8006 Fax	☐ CŜyǘŜꟷ Ŧƻꟷ !ŎǘǞØŜ [ǞØǞyƎ (719) 255- 80ст (719) 255- 8044 Fax
☐ Peak Nutrition Clinic (719) 255- 7524 (719) 255- 8044 Fax	☐ Nurse-Family Partnership© όтмфύ нррπулпф
☐ Veterans Health ϑ Trauma (719) 255- 8003 (719) 255- 8075 Fax	☐ Primary Care Clinic (719) 255- 8001 (719) 255- 8044 Fax

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/ity, State, Zipᵞ _ψ_____________________________ψψ

Phone:_______________ψ__Cl·ÈY __________ψ_ψ____

turpose:

☐ Continuity of Care
☐ Personal Use
☐ Legal
☐ Coordination of Care

☐ Other __________________ψψψψψψψψψ____

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☐ /ťǘyǞŎ tꟷƻƎꟷŜăă bƻǘŜă	☐ Radiology LYl·ƎŜă
☐ a Ŝyǘl·ť I Ŝl·ťǘK ¢ꟷŜl·ǘYŜyǘ	☐ hǘKŜꟷ

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☐ wŜťŜl·ăŜ ¢ƻᵞ (ReŎŜǞØǞyƎ facility)

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Address: ψψψψψψψψψψψψψψψψψψψψψψψψ________ψψ

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Purpose:

☐ Continuity of Care
☐ Personal Use
☐ Legal
☐ Coordination of Care

☐ Other __________________ψψψψψψψψψ____

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Date of Service Range (mƻnth/yŜl·r):

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AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, and further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and **THERE MAY BE A COST TO COPY THE RECORDS OR WRITE A TREATMENT SUMMARY.**

I understand there are limited exceptions to these provisions in the Colorado Statutes. These require reporting of threats of violence, harm, or child or elder abuse and neglect (from either evidence or suspicion), or when subpoenaed by the courts, to proper authorities. Certain other exceptions exist and will be explained as necessary.

I understand that **this consent expires the sooner of one year from the date of my signature or 6 months from the last appointment** unless otherwise specified as follows: _____ I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date of this authorization. A copy, fax, or scan of this form is to be considered as valid as the original.

_____ _____

Signature of Patient or Authorized Representative **Date of Signature**

_____ _____

Printed Name **Relationship to Patient (if applicable)**

(Please Provide a Copy of This Form to the Patient)

Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated above:

_____ _____

Signature of Patient or Personal Representative Date