Colorado Mountain Medical
Doctors you know and trust

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AUTHORIZATION FOR THE RELEASE OF PATIENT PROTECTED HEALTH INFORMATION TO A THIRD PARTY

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

I authorize **Colorado Mountain Medical** to disclose my protected health information* to _____

Relationship to patient: _____

For the purpose of:
____Continuity of Medical Care _____Damage/Claim Information ____Personal Other:_____

***I understand that my medical records/protected health information may contain information concerning my mental health and/ or psychiatric treatment, drug and/or alcohol treatment as well as any HIV test results (AIDS).**

___ Authorize Release ___ Do **NOT** Authorize Release ___ Not applicable

INFORMATION TO BE RELEASED (check all that apply):

☐ I authorize the above named individual(s) or facility to verbally speak with Colorado Mountain Medical regarding my protected health information (PHI), and have access to, **ALL information** contained in my PHI record.

OR

☐ I authorize the above named individual(s) or facility to verbally speak with Colorado Mountain Medical regarding my protected health information (PHI), and have access to, **only the following information** contained in my PHI record that I have checked below:

Date of Service range (month/year): From: _____ To:_____

___Emergency Room Report	___Mental Health Treatment	___Genetic Information
___Discharge Summary	___Drug/Alcohol Treatment	___HIV/AIDS
___Operative Report	___Radiology Reports	___Billing _____
___History & Physical	___Laboratory Reports	___Other:_____
___Clinic/Progress Notes	___Other Test Results	_____
___Immunization Records		

Authorization for the use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Colorado Mountain Medical, PC may not use or disclosure your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating a separate revocation form and returning the form to this office.

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 long be protected by Colorado Mountain Medical. I understand that this authorization is voluntary, that further treatment can not be conditioned upon signing this authorization and that there may be a cost to copy records.

AUTHORIZATION: I understand that 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 that this consent will expire 190 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile 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)**