



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_
(Patient or Legal Representative(s)) (Name of physician / health care provider releasing records)
to disclose to:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip \_\_\_\_\_

The following protected health care information:

[ ] ONLY the following specific information: \_\_\_\_\_ History/Physical \_\_\_\_\_ Discharge Summary \_\_\_\_\_ Operative Report
\_\_\_\_\_ Pathology Report \_\_\_\_\_ Laboratory Report \_\_\_\_\_ ER Report \_\_\_\_\_ Other (specify) \_\_\_\_\_

[ ] Entire medical record for specified date(s) of service: From: \_\_\_\_\_ To: \_\_\_\_\_

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically
restricted below: Please initial

\_\_\_\_\_ Psychological / psychiatric conditions \_\_\_\_\_ Drug and/or alcohol abuse diagnosis and/or treatment
\_\_\_\_\_ HIV/AIDS diagnosis and/or testing

List any restrictions: \_\_\_\_\_

The purpose of the disclosure is: \_\_\_\_\_

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance
Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the
recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit
redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am
authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my
decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in
reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to
contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed
physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this
authorization form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of
this form if I so request.

Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year.

Signature of Patient or Legal Representative(s): \_\_\_\_\_

(Note: If patient is a minor child, both parents may be required by law to sign)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Printed Name(s): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ (if signed by other than patient)

Per the Colorado Department of Public Health and Environment: "The ... patient or representative shall pay for the reasonable cost of obtaining a
copy of his/her patient record, not to exceed \$14.00 for the first ten or few pages, \$0.50 per page for pages 11-40, and \$0.33 per page for every
additional page. Actual postage or shipping costs ... also may be charged."

Copying and postage costs are waived when Longmont United Hospital sends the records directly to another healthcare provider for the purpose of
continuing care.