Avista Adventist Hospital
Centura Health.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Fax # (303) 673-1026

Patient Name:_____ Social Security #:_____

Address:_____ Birthdate:_____

Telephone:_____ Medical Record #:_____

Medical Information From:	Release to: (Name, Address, Phone)

I authorize the above-named health care provider to disclose the medical information specified below to the organization, agency, or individual name on this request:

INFORMATION REQUESTED:

Place/Dates of Service _____

Kind and amount of information to be disclosed _____

Purpose of disclosure/why information required _____

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS). (Protected by State law)

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee. I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. **This authorization expires:**_____

If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the facility privacy officer or their designee.

SIGNATURE:_____ DATE:_____

Patient (Parent or Guardian if patient is a minor)

Minor's signature is required for release of any records for treatment, which the minor may authorize under Colorado Law.

RELATIONSHIP (if other than patient):_____

IDENTIFICATION OF PATIENT OR DESIGNATED REPRESENTATIVE:

☐ Drivers License # _____ ☐ Passport # _____

☐ State ID # _____ ☐ Other ID # _____

State ID is from _____ ID Expiration _____

CLERK SIGNATURE:_____ DATE:_____