Littleton Adventist Hospital

Centura Health.

HIM AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
HI051L (07/09)

LITTLETON ADVENTIST HOSPITAL
7700 S. BROADWAY, LITTLETON, CO 80122
PHONE: 303-730-5812 • FAX: 303-798-9824
Hours of Operation
Monday – Friday 8:00am – 4:00pm

☐ Mail
☐ Patient Pick up
☐ Fee Approval

AUTHPHIDBL

HIM AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name	Date of Birth

Address: _____ Telephone # ( ) _____

City: _____ State: _____ Zip Code: _____

I hereby authorize LITTLETON ADVENTIST HOSPITAL to disclose/release the Protected Health Information (PHI) to the name listed below (If releasing records to yourself please check self): ☐ **SELF**

Name: _____ (Relationship) _____

Address: _____ Telephone # ( ) _____

City: _____ State: _____ Zip Code: _____ Fax # ( ) _____

Purpose:
☐ Further Medical Care ☐ Insurance ☐ Workers' Comp
☐ Legal ☐ Military ☐ Personal Use
☐ Other: _____

Type of Access Requested:
☐ Copies of the Record
☐ Review of the Record

Information Requested

Pertinent Information:
☐ Discharge Summary ☐ Lab
☐ History & Physical ☐ X-ray
☐ Consultation Report ☐ ER Report
☐ Discharge Instructions ☐ EKG
☐ Other: _____

Selected Portions of PHI:
☐ Physician Progress Notes and Orders
☐ Medication Records
☐ Psych Health Records
☐ Other: _____
☐ Specific Date of Service: _____
_____

The Charges and the Process for Receiving Records

- Due to the large volume of medical record requests we receive, please allow us up to 10 business days to complete your request.
- Fees for copies of records are pursuant to Colorado State Statute:

$14.00 for the first ten or fewer pages
$.50 per page for pages 11-40
$.33 per page for every additional page over 40

- No fee will be charged for records that are sent directly to a health care provider solely for the purpose of providing continuing medical care to the patient.
- No fee will be charged for the viewing of medical records by the patient or patient representative. All appointments to view medical records shall be made 72 hours in advance.

→ See other side of page to sign and date authorization →

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's 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. 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 A FEE WILL BE CHARGED FOR COPIES OF MY MEDICAL RECORDS**. I understand the facility will provide me a copy of the signed authorization form. If I have any questions about disclosure of my health information, I can contact the facility Privacy Officer or their designee.

EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless otherwise specified: _____

ACKNOWLEDGEMENT: I request and authorize Littleton Adventist Hospital to release the information specified above to the organization, agency, or individual named on this request. I understand that the information to be released may include information regarding: **Psychological or Psychiatric Conditions; **Drug Abuse, Alcoholism, Alcohol Abuse; **Human Immunodeficiency Virus (HIV); **Acquired Immune Deficiency Syndrome (AIDS); **Sexually transmitted disease (STD); **Sickle Cell Anemia, **Hepatitis.

SIGNATURE: _____ **DATE:** _____
Patient (Parent or Guardian if patient is a minor)

PRINT NAME: _____ **RELATIONSHIP:** _____
Minor's signature is required for release of any treatment which the minor may authorize under Colorado Law.

VERIFICATION:

☐ Driver's License # or other appropriate ID _____ ☐ Power of Attorney ☐ Death Certificate

This portion is for Medical Records Associates only

☐ Discharge Summary	☐ Consult	☐ Pathology	☐ X-ray	☐ EEG/EMG
☐ Face Sheet	☐ Op Report	☐ Prog/orders	☐ EKG	☐ Psych Eval
☐ H&P	☐ GI	☐ Nursing Notes	☐ Echo	☐ Pertinent
☐ ER	☐ Cath	☐ Lab	☐ Stress	☐ Complete
☐ Anesth	☐ Other: _____			

Date Received: _____ Date Copied: _____ # of pages: _____