

### Authorization for Use and Disclosure of Personal Health Information

• 1905 Blake Avenue Suite 101, Glenwood Springs, CO 81601 • 123 Emma Road Basalt, CO 81621 • 195 West 14<sup>th</sup> Street Building C Rifle, CO 81650 • 230 Chapel Place Avon, CO 81620 • 410 McGregor Drive Gypsum, CO 81637 • School Based Health Centers

<b>Patient Information</b>	<b>Name:</b> _____ <b>Date of birth:</b> _____ <b>Address:</b> _____ <span style="margin-left: 300px;">(City/State/Zip)</span> <b>Phone number:</b> _____ <b>E-mail:</b> _____	
<b>Mountain Family Health Center fax numbers</b> • Glenwood Springs 970-945-2893 • Rifle 970-625-4150 • Basalt 970-927-0171 • Avon 970-569-3435 • Gypsum 970-945-1055		
<b>Authorization to release/receive protected health information (PHI)</b>	<b>I authorize Mountain Family Health Centers, including all affiliated locations, to:</b> <input type="checkbox"/> <b>RELEASE</b> my protected health information <input type="checkbox"/> <b>RECEIVE</b> my protected health information	
<b>Recipient Information</b>	<b>Name/Facility:</b> _____ <b>Address:</b> _____ <b>City/State/Zip:</b> _____ <b>Phone:</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	
<b>Information to be released and dates of service</b>	<b>I request that the following PHI be released from my medical record</b> <b>Dates of service (Month/Day/Year):</b> _____ <b>to</b> _____ <input type="checkbox"/> <b>Complete medical records</b> <input type="checkbox"/> Office visit notes <input type="checkbox"/> Dental records <input type="checkbox"/> Billing/Financial information <input type="checkbox"/> Radiology reports <input type="checkbox"/> Labs/Pathology report <input type="checkbox"/> Immunization record <input type="checkbox"/> Medication list <input type="checkbox"/> Behavioral health records <input type="checkbox"/> Other/Condition: _____	
<b>Purpose of disclosure and delivery method</b>	<b>Purpose of disclosure</b> <input type="checkbox"/> Personal <input type="checkbox"/> Legal/Attorney <input type="checkbox"/> Disability <input type="checkbox"/> Insurance <input type="checkbox"/> Dissatisfied <input type="checkbox"/> Transferred care- <i>why?</i> _____	<b>Preferred method of delivery</b> <input type="checkbox"/> US Mail <input type="checkbox"/> Fax <input type="checkbox"/> E-mail <input type="checkbox"/> Personal pick-up
<b>Revocation</b>	I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the Health Information Records Manager. This does <b>not</b> apply to information that has already been disclosed in response to this authorization.	
<b>Sensitive information and Behavioral Health records</b>	<b>BY SIGNING THIS AUTHORIZATION, I UNDERSTAND THAT MY HEALTH RECORDS MAY CONTAIN SENSITIVE INFORMATION, INCLUDING BUT NOT LIMITED TO: sexually transmitted infections (STIs), HIV/AIDS status, Behavioral health services (such as mental health treatment), and records related to the diagnosis or treatment of alcohol, drug, or substance use disorders.</b> _____ <span style="float: right;">(Initials)</span> <ul style="list-style-type: none"> <li>I understand that Behavioral Health records are protected under <b>42 CFR Part 2</b>, and this release complies with those regulations.</li> </ul>	
<b>Expiration date</b>	This authorization will expire on the following date, event, or condition: _____. If not specified, this authorization will expire <b>12 months</b> from the date of signature.	
<b>Authorization details</b>	<ul style="list-style-type: none"> <li>Records will be released within 7-10 business days. If records are needed urgently, please notify a staff member. If this request is mailed or faxed, please attach a copy of your picture ID.</li> <li>Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.</li> <li>I understand that if the person(s) or entity(ies) that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information described above <b>may</b> be re-disclosed and no longer protected by those regulations. Therefore, I release Mountain Family Health Centers, physicians, and employees there in, from all liability arising from this disclosure of my personal health information.</li> </ul>	
	_____ <i>Signature of patient/patient representative</i>	_____ <i>Date</i>
	_____ <i>Print name</i>	_____ <i>Relationship to patient</i>

**Note:** Request with incomplete or incorrect information will not be processed. Records will not be released until all errors are corrected, which will cause a delay in your request!