



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient's Date of Birth: _____ Chart # _____

I, _____, authorize Pueblo Community Health Center, Inc., or
Name of Patient or Legal Representative(s)

To disclose the following protected health care information:

Health Care Provider Releasing Records

Patient's entire (check applicable records) Medical, Dental, and/or Mental Health record. (Note—Psychotherapy notes are not disclosed.)

Patient entire records for specified date(s) of services.

From: _____ To: _____
M/D/YYYY M/D/YYYY

ONLY the following specific information:

The following entity is authorized to Receive Disclose (mark one) my health care information:

Name: _____ Phone: _____

Address: _____ Fax: _____
Street number, name, city, state, and zip

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below: • Psychological/psychiatric conditions • Drug and/or alcohol abuse diagnosis and/or treatment • HIV/AIDS diagnosis and/or testing • Sexually transmitted disease(s) diagnosis and/or testing • Genetic testing

List any restrictions: _____

The purpose of the disclosure is: _____

Re-disclosure or 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 re-disclosing it. Other laws; however, may prohibit re-disclosure.

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 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 written revocation.

Right to Inspect (by appointment): I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization for. *Patient needs to contact the Medical Records Supervisor to make an appointment.*

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I may request a signed copy of this form.

Expiration Date: This authorization will expire on _____ (M/D/YYYY) or _____
(indicate a specific event). I understand I can revoke this authorization at any time by submitting a written request to the Medical Records Supervisor.

Signature of Patient or Legal Representative(s): _____
(Note: If a patient is a minor child, both parents may be required by law to sign)

Today's Date: _____ Printed Name(s): _____

Relationship to Patient: _____