



**Pueblo
Community
Health Center**

Pueblo Community Health Center, Inc.
110 East Routt Avenue
Pueblo, CO 81004
719-543-8711 (Phone) 719-543-0171 (Fax)

Authorization for the Use or Disclose of Protected Health Information

Patient Name: _____ DOB: _____ Medical Record # _____

Address: _____

Telephone # _____ E-mail Address _____

I, _____, authorize **Pueblo Community Health Center, Inc.** to **Release / Receive** medical records
(Patient or Legal Representative) (Circle One)

To / From (Circle One)

Name: _____ Phone: _____

Address: _____

Only the following specific information: Other _____ Date(s) of Service: _____

Or:

Entire Medical Record and for specified date(s) of service: From: _____ To: _____
("Present" equals date of signature)

Behavioral Health and for specified dates(s) of service: From: _____ To: _____
("Present" equals date of signature)

Dental and for specified dates(s) of service: From: _____ To: _____
("Present" equals date of signature)

Information to be released by: Paper Electronic

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 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 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 a claim under the policy. To revoke this authorization, I will provide the Medical Records Department, 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: This authorization is in effect for ninety (90) days (unless I provide a written revocation at an earlier date)

Signature of Patient or Legal Representative(s): _____ **Date:** ____ / ____ / ____

Printed Name(s): _____ Relationship to Patient: _____
(if signed by other than patient)

Staff Initials _____