

University of Colorado Hospital

12401 E. 17th Avenue - Box A025
Aurora, CO 80045
(720) 848-1031 Phone (720) 848-5551 Fax

UCH Psychiatric Services

(720) 848-6190 Phone (720) 848-5549 Fax

Medical Record #

Patient Name(s)

Date of Birth

Social Security #

Contact Phone #

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

OBTAIN FROM: (Releasing facility)			RELEASE TO: (Receiving entity)		
Name			Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

INFORMATION TO BE REVIEWED: IN ELECTRONIC MEDICAL RECORD ONLY

DURING PATIENT ADMISSION/VISIT IN HEALTH INFORMATION DEPARTMENT

INFORMATION TO BE PHOTOCOPIED AND RELEASED (CHECK ALL THAT APPLY):

Date of service range (month/year): From: _____ To: _____

- | | | |
|--|--|---|
| <input type="checkbox"/> Emergency Room Report | <input type="checkbox"/> Mental Health Treatment | <input type="checkbox"/> Genetic Information |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> HIV/AIDS Information |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Radiology Images |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Clinic/Progress Notes | <input type="checkbox"/> Immunization Records | |

THE PURPOSE FOR THIS RELEASE:

Continuity of Medical Care Damage/Claim Information Personal Use Legal

Other: _____

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment can not be conditioned upon my signing this authorization. I acknowledge that incomplete forms can not be processed and **THAT THERE MAY BE A COST TO COPY THE RECORDS.**

I understand that **this consent expires 180 days from the date of my signature** unless otherwise specified as follows:

_____ I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax or scan of this form is to be considered as valid as the original.

Signature of Patient or Authorized Representative

Date of Signature

Printed Name

Relationship to Patient (if applicable)

ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS: I hereby acknowledge that I have reviewed/received the medical records from the University of Colorado Hospital on the above named patient.

Date

Signature

Date

Witness Signature