BACTES
Security | Compliance | Trust

CSHP MRN: ______________________

CSHP Medical Records Department
6025 Delmonico Dr., Colorado Springs, CO 80919
Phone: 719-265-3073 Fax: 719-260-5646

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Individual authorization for the use and disclosure of individually identifiable health information other than for treatment, payment, and/or health care operations.

Reason for this request (please mark all that apply):

❐ Insurance change ❐ Moving ❐ Legal action ❐ Referral

❐ Dissatisfied w/ doctor ❐ Dissatisfied w/ service at CSHP ❐ Personal Use

❐ Other (please specify): ____

Patient Identification (please print):

Name:____ **Date of Birth:** ______/______/________

Phone Number: ____

I understand that, as a part of my health care, Colorado Springs Health Partners (CSHP) receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that CSHP and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations.

Extent of information to be released:

I would like copies of specific reports of the treatment dates listed INSTEAD OF ALL:

❐ Physician notes ❐ Radiology reports** ❐ Laboratory reports
❐ Immunizations ❐ Operative reports ❐ Physical Therapy notes
❐ Outside Records ❐ Diagnostic test reports ❐ Workers' Compensation

❐ Only records of Doctor _______________________________________.

❐ Between dates of ____________________ to ____________________.

❐ **ALL** dates of treatment by any/**all CSHP provider(s).**

❐ Other (please specify) ____

*** **Radiology films** must be requested and obtained from the CSHP Radiology Department*

Continued on reverse

MUST BE INITIALED: You <u>must</u> initial the appropriate section(s) if you wish such information to be included with this request:

______ **Alcoholism and/or Drug Abuse/Dependence:** The records relating to the diagnosis and/or treatment of alcoholism and/or drug abuse or dependence may be released to the recipient noted on this authorization.

______ **Mental Health/Rehabilitation:** The records relating to the diagnosis and/or treatment concerning mental Health/Rehabilitation may be released to the recipient noted on this authorization.

______ **HIV/AIDS:** The records relating to the diagnosis and/or treatment for HIV/AIDS may be released to the recipient noted on this authorization.

______ **Genetic Information:** The records relating to genetic information may be released to the recipient noted on this authorization.

I understand that only the areas marked at the time this release was signed will be released/disclosed.

I understand that I may revoke this consent in writing but the revocation will not affect the extent that CSHP has already taken action in reliance on my earlier effective consent.

I understand that I must deliver the written revocation to CSHP Medical Records in person or by Certified Mail.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may be no longer be protected by the HIPAA privacy regulations.

I understand I may request a copy of this release.

A copy of this authorization may be used with the same effectiveness as the original.

I hereby knowingly and voluntarily authorize CSHP to disclose the information to:

*[Please PRINT the **name, address, or email address** of person or entity you are authorizing to receive your health information]*____

____

This authorization expires 1 year from the date of my signature unless I request an expiration date less than 1 year. *If less than 1 year, expires*: ______________________________

______________________________ ______________________________

Signature of Patient/Responsible Party Signature of Witness/ID Checked

Date: ______________________________ **Date:** ______________________________

If the authorization is signed by a personal representative, a description of the representative's authority to act follows:

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______________________________ ______________________________

Signature of Legal Representative Signature of Witness/ID Checked

Date: ______________________________ **Date:** ______________________________

If mailing or faxing this release, please include a copy of your driver's license. Please direct any questions regarding this release to: CSHP Medical Record Release 719-265-3073.