HEART OF THE ROCKIES
REGIONAL MEDICAL CENTER

Date received/initials: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name				Date of Birth
Mailing Address	City	State	Zip	Phone Number

I hereby authorize Heart of the Rockies Regional Medical Center to disclose or obtain my health information:

DISCLOSE RECORD(S) TO:	OBTAIN RECORD(S) FROM:
Name _____	Name _____
Attention _____	**Attention** _____
Mailing Address _____	Mailing Address _____
City/State/Zip _____	City/State/Zip _____
Phone _____ Fax _____	Phone _____ Fax _____
Email _____	Email _____

I specifically authorize the use and disclosure of the following:

☐	Discharge Summary	☐	ED Physician Note	☐	Clinic Notes / Provider Name:
☐	History & Physical	☐	Laboratory Reports	☐	Direct Access Testing Results
☐	Consultation Reports	☐	Radiology Reports	☐	All Records
☐	Operative/Procedure Reports	☐	Radiology CD Rom	☐	Other:

RECORDS CONTAINING SENSITIVE INFORMATION:

The information to be used or disclosed pursuant to this authorization may include information relating to: AIDS or HIV infection, sexually transmitted diseases, treatment of drug and/or alcohol, mental health or psychiatric care, or genetic testing.

I do NOT authorize release of the following: _____

Dates of treatment:
Specific dates: _____ to _____

Disclosure format – check all that apply:
☐ Paper (default) ☐ Fax ☐ Email–secure format (address required)

Purpose of this release:
☐ Treatment/continuation of care ☐ Patient request ☐ Insurance ☐ Legal ☐ Other _____

By signing this authorization, I understand the following:

- I have read the above information and authorize disclosure of the identified information to the person/organization and for the purpose described herein. I understand that to receive copies of my records I must provide photo identification. I also understand that in certain circumstances I may be asked to provide additional documentation.
- I may be charged fees for copying of such information if I am requesting information for myself or for a third party. Such fees will comply with federal and state laws.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the HRRMC Medical Records Department. Revocation will not apply to information that has already been disclosed in reliance on this authorization.
- Unless otherwise revoked, this authorization **will expire one year from the date of signature.**
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- I understand that once this information is disclosed, it may no longer be protected.

_____ _____
Patient or Authorized Representative **Signature** Date Signed

_____ _____
Patient or Authorized Representative **Printed** Name Authority or Relationship to Patient (if applicable)

OFFICE USE	Please process/date: Initials:	ID Verified/Initials:	Date requestor recv'd records:
Date processed/**QA** completed: Initials:		Scanned: ☐ Aprima ☐ CPSI Initials:	