Boulder Community Health

Medical Record # _____ ROI # _____

Patient Information

Full Name _____ Date of Birth _____

Maiden or Other Names Used _____ Social Security Number: XXX-XX- _____ (last 4 digits)

Address _____

Day Phone # _____ Cell # _____ City _____ State_____Zip _____

Release Information From

Hospital/Clinic Name: _____

Address _____

Phone # _____ FAX # _____ City _____State_____Zip _____

Release To

Recipient Name: _____

Address _____

Phone # _____ FAX # _____ City _____State_____Zip _____

Purpose

❑ Continuation of Care ❑ Insurance/WC ❑ Legal

❑ Personal ❑ Other (Specify): _____

Date(s) Of Information to be Released

Date(s) of Service From _____ through _____

Date(s) of Service From _____ through _____

Information to be Released/Accessed

I would like copies of the items checked below for the treatment dates listed above.

ONLY the following:

❑ Emergency Report ❑ Discharge Summary ❑ History & Physical ❑ Imaging CD/ Film (MRI/CT/X-Ray/Ultrasound)

❑ Operative Report ❑ Consultation ❑ Laboratory

❑ Clinic Visit ❑ Billing Records ❑ Cardiac Studies/ EKG ❑ Imaging Report

❑ Behavioral Health ❑ Other: _____

❑ Pertinent medical record – (Default for patient requests: Discharge Summary, H&P, Operative Report, Emergency Report, Consultation)

❑ Entire medical record (Legal medical record)

Disclosure/Access Format

I would like copies of the items checked above in the following format: (Paper format-US Mail is default if not marked)

❑ Paper Format – US Mail ❑ CD ❑ USB ❑ Fax (Healthcare provider Only) ❑ Other _____

❑ Paper Format – Pick-Up ❑ Review Only ❑ Encrypted Email to: _____

I Understand That

- Without my express revocation, this authorization will automatically **expire** 180 days from the date signed below, unless a different date is specified here: _____
- I may **revoke** this authorization in writing at any time, except to the extent that action has already been taken to comply with it. Information disclosed pursuant to the authorization may be subject to **redisclosure** by the recipient and is no longer protected by the HIPAA Privacy rule.
- I understand that BCH may not refuse treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the treatment provided is to be solely for the purpose of creating protected health information for disclosure to the party listed in this authorization. I understand that except for drug and alcohol treatment records, information disclosed under this authorization may be redisclosed by the recipient and is no longer protected by privacy laws.
- Treatment, Payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.

_____ _____ _____

Signature of Patient/Guardian/Personal Representative **Relationship** **Date**

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law

_____

Personal Representative's PRINTED Name, Address, and Phone Number

ROI

Place Label Here