

Patient Legal Name _____ Birthdate _____ SS# _____
 Address/City/State/Zip _____
 Telephone number: _____ Unit Number: _____

I hereby authorize:
 The Medical Center of Aurora Rose Medical Center
 Centennial Medical Plaza North Suburban Med Center
 Presbyterian/St. Luke's Med Center Sky Ridge Medical Center
 Spalding Rehabilitation Hospital Swedish Medical Center
 OTHER: _____

Name / Title / Organization _____
 Address/City/State/Zip _____
 Telephone# _____ Fax# _____

Continuation of Care Insurance or Worker's Comp Legal Personal Use
 Other _____ For treatment date(s): _____

Copies of the record D/C Summary 9 H&P Outpatient Visit Behavioral Health Record
 Inspection of the record Consult/Operative Report Special Studies Entire Medical Record
 Lab/Radiology Physician Orders Billing Record
 Emergency Room Record Medication Record Other _____

ACKNOWLEDGEMENT: I request and authorize the above-named health care provider to release the information specified above to the organization or individual named on this request. I understand that the information to be released may include information regarding the following condition(s): Sickle Cell Anemia; Genetic testing; Human Immunodeficiency Virus (HIV); Drug Abuse, Alcoholism, Alcohol Abuse, if any; Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any

- I understand that:
1. My signature on this form is strictly voluntary.
 2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy of Practices.
 3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations.
 4. Fees/charges will comply with all laws and regulations applicable to release of information.

Note: HealthONE may charge a fee for copies of the medical records in accordance to Colorado State Law.

PHYSICIAN CONCURRENCE FOR PATIENT ACCESS:
 _____ has my permission to (inspect) (receive copies of) the requested medical records. I have reviewed the medical record(s) and have determined they (do) (do not) contain information relative to psychological or psychiatric problems, which, if revealed to the patient, would be reasonably likely to endanger the life or physical safety of the patient or another person. (If the patient has requested psychotherapy notes, such disclosure (would) (would not) have significant negative psychological impact upon the patient.)

Attending physician or designee: _____ Date: _____

Call requestor for pick-up when records are ready.
 Mail records directly to person or organization specified.

I authorize _____ to pick up my Protected Health Information (PHI).
 (Print Name) _____

Relationship _____

Confirmation of PICK-UP
 Signature _____
 Date _____

My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

Date _____ Patient or Authorized Representative _____ Relationship to Patient _____
 A copy is provided after signature.

EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified as follows: _____

OTHER CONDITIONS: A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.



Authorization for Use and Disclosure of Protected Health Information (PHI)

HealthONE USE ONLY
Verification:
 Date Authorization Received: _____ By: _____
 Date Request Completed: _____ By: _____
 Identification/Driver's License # Verified: _____
 Power of Attorney Other _____