Patient Information

Patient Legal Name _____ Birthdate _____ SS # _____

Address/City/State/Zip _____

Telephone number: _____ Unit Number: _____

Release From:

I hereby authorize:

☐ The Medical Center of Aurora
☐ Centennial Medical Plaza
☐ Presbyterian/St. Luke's Med Center
☐ Spalding Rehabilitation Hospital
☐ Other _____
☐ Rose Medical Center
☐ North Suburban Med Center
☐ Sky Ridge Medical Center
☐ Swedish Medical Center
☐ Swedish Southwest ER

Release To:

_____
Name / Title / Organization

_____
Address / City / State / Zip

Telephone # _____ Fax # _____

Purpose

☐ Continuation of Care ☐ Insurance or Worker's Comp ☐ Legal ☐ Personal Use

Other _____ For treatment date(s): _____

Access Requested:

☐ Copies of the record

☐ Inspection of the record

Pertinent Info:

☐ D/C Summary ☐ H&P
☐ Consult/Operative Report
☐ Lab/Radiology
☐ Emergency Room Record

Selected Portions:

☐ Outpatient Visit ☐ Behavioral Health Record
☐ Special Studies ☐ Entire Medical Record
☐ Physician Orders ☐ Billing Record
☐ Medication Record ☐ Other _____

Patient Authorization:

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.

Fees:

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

Phys Concurrence: if Applicable:

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, could be harmful to the patient's well being.

_____ _____
Attending physician or designee Date

Delivery Instructions:

☐ 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

Signature:

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.

HealthONE

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 _____