UMC
UNCOMPAHGRE MEDICAL CENTER

Patient Authorization to Disclose Protected Health Information Form: To UMC

Patient Name:	**Date of Birth**	**Last 4 SS#**	**Contact/Phone Number**

Release From:
Organization/person: _____
Phone/and fax_____
Email and address _____

Release To:
Uncompahgre Medical Center
1350 Aspen Street, PO Box 280
Norwood, CO 81423
bhannigan@umclinic.org
Phone: (970) 327-4233
Fax: (970) 327-4228

Delivering Instructions: ☐ MAIL ☐ FAX ☐ CALL TO PICK UP: _____
☐ ELECTRONIC (flash drive, email etc.)

Date(s) of Service: From: _____ To: _____

Purpose of Disclosure: ☐ Personal Use ☐ Continuity of Care ☐ Transfer of Care
☐ Other _____ ☐ Legal (subpoena required)

Type of Information to be Disclosed: (check all that apply)
☐ Medical ☐ Dental ☐ Behavioral Health

Protected Health Information to be Disclosed: ☐ Balance/Payment ☐ Encounter/Progress note
☐ Immunizations ☐ Entire Record ☐ Medications ☐ Lab Results ☐ Other _____

Re-disclosure: I understand if I have authorized disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and no longer protected. I understand I have a right to confidentiality and protection of substance use and HIV/AIDS status records (CFR 42 Part 2, CRS 25.1, HIPAA) except where legally required or permitted and information should not be released without my written consent.

Right to Revoke: I understand I have the right to revoke this authorization at any time and it must be submitted in writing. If I revoke this authorization, it will not have any effect on information disclosed prior to receiving the revocation.

Expiration: Without my written revocation, this authorization will automatically expire in one year or _____, whichever occurs first.
(specify event or date)

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may refuse to sign this authorization and refusal will not affect my ability to obtain treatments unless treatment is required by court order.

Acknowledgment: I understand the terms of this consent and that, upon request, may obtain information on the disclosures. I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, deficiency syndrome (AIDS) or family planning/contraception. If you do not wish any of the information described above to be released, please indicate below:

Type of information to be excluded: _____Initials: _____

_____ _____
Patient Signature (*Representative/ Parent/Legal Guardian) **Date**

By signing as the Representative/ Parent/ Legal Guardian, I am representing that I have legal authority to do so and that my ability to sign on behalf of the patient has not been limited or restricted either voluntarily or through legal process. Verification of legal documents may be requested.

_____
Printed Name of Individual Signing on Patient's Behalf Relationship to Patient

REVOCATION: I revoke my authorization for this use and disclosure of my health information prior to the one-year expiration date.
Printed Name: Signature: Date: