

## Patient Authorization to Disclose Protected Health Information Form

Patient Name	Date of Birth	Last 4 SS#	Contact/Phone Number
I hereby authorize the <b>Axis Health System</b> facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or individual named. <input type="checkbox"/> Written <input type="checkbox"/> Verbal			
<b>Release</b> <input type="checkbox"/> From <input type="checkbox"/> To: <b>Axis Health System</b>			
<b>Columbine Center</b> PO Box 1328, Durango, CO 81302		T 970.259.2162	F 970.247.7885
<b>Cortez Integrated Healthcare</b> 691 E. Empire St, Cortez, CO 81321		T 970.565.7946	F 970.565.9005
<b>Crossroads ATU</b> 1125 Three Springs Blvd, Durango, CO 81301		T 970.403.0182	F 970.403.0191
<b>Crossroads Detox</b> 1125 Three Springs Blvd, Durango, CO 81301		T 970.259.8732	F 970.259.8734
<b>Crossroads RCT</b> 1125 Three Springs Blvd. Durango, CO 81301		T 970.403.0180	F 970.403.0190
<b>La Plata Integrated Healthcare</b> 1970 E 3 <sup>rd</sup> Ave, Unit 1 Lower Level, Durango, CO 81301		T 970.335.2288	F 970.335.2280
<b>Oral Health Clinic</b> 2530 Colorado Ave., Suite A, Durango, CO 81301		T 970.335.2442	F 970.335.2402
<b>Archuleta Integrated Healthcare</b> 185 Suttle St., Durango, CO 81301 (mailing address)		T 970-264-2104	F 970.264.2108
<b>Release</b> <input type="checkbox"/> From <input type="checkbox"/> To: <input type="checkbox"/> Treating Providers, all current and future, located at: _____ (e.g. Pediatric Partners) <input type="checkbox"/> Organization or Agency: _____ Person or Job Title: _____ Mailing Address: _____ City, State, Zip Code: _____			
<b>Type of Disclosure Authorized &amp; Delivery Instructions:</b> <input type="checkbox"/> Mail records directly to address above <input type="checkbox"/> Fax records to: _____ <input type="checkbox"/> Call to pick-up records: _____ <input type="checkbox"/> CD (email address required for password & software download): _____			
<b>Treatment Dates:</b> Dates from: _____ through _____			
<b>Purpose of Disclosure: The information may be disclosed for treatment, payment, healthcare operations, and the following purposes</b> <input type="checkbox"/> At Request of Patient <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> Multi-agency Coordination <input type="checkbox"/> Testimony <input type="checkbox"/> Other: _____			
<b>Type of Information to be Disclosed:</b> <input type="checkbox"/> Primary Care <input type="checkbox"/> Mental Health/Psychiatric <input type="checkbox"/> Substance Use <input type="checkbox"/> Dental			
<b>Protected Health Information to be Disclosed:</b> <input type="checkbox"/> Encounter/Progress Notes or Visit Notes <input type="checkbox"/> Treatment/Service Plan <input type="checkbox"/> Attendance <input type="checkbox"/> Immunizations <input type="checkbox"/> Entire Record <input type="checkbox"/> Balance/Payment <input type="checkbox"/> Lab Results <input type="checkbox"/> Other: _____ <input type="checkbox"/> Diagnostic Evaluation/Assessment Update <input type="checkbox"/> Medications _____ <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Problem List _____			
<b>Re-disclosure:</b> 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 (C.F.R. 42 Part 2, C.R.S 25.1, HIPAA) except where legally required or permitted and information should not be released without my written consent.			
<b>Right to Revoke:</b> 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.			
<b>Expiration:</b> Without my written revocation, this authorization will automatically expire in two years or _____, whichever occurs first. <div style="text-align: right;">Specify event or date</div>			
<b>Authorization:</b> 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 treatment unless treatment is required by court order. I understand a fee may be charged for copies of my health records. I may request a copy of this signed authorization at any time. If I have questions regarding disclosure of my health information, I may contact the Privacy Officer.			
<b>Acknowledgement:</b> 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, mental health or psychiatric conditions, substance use disorders, human immunodeficiency virus (HIV) or acquired immune 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	
<b>Revocation:</b> I revoke my authorization for this use and disclosure of my health information.			
_____ Patient Signature (*Representative/Parent/Legal Guardian)		_____ Date	
<b>(AHS Use Only) Signature Verification:</b> <input type="checkbox"/> Driver's License <input type="checkbox"/> Other State-Issued ID or previously signed document in chart			
(AHS Use Only) Patient # _____			