AXISHealth System

Patient Authorization to Disclose Protected Health Information Form

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

I hereby authorize the **Axis Health System** facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or individual named. ☐Written ☐Verbal

Release ☐From ☐To: Axis Health System

	Columbine Center PO Box 1328, Durango, CO 81302	**T** 970.259.2162	**F 970.247.7885**
	Cortez Integrated Healthcare 691 E. Empire St, Cortez, CO 81321	**T** 970.565.7946	**F 970.565.9005**
	Crossroads ATU 1125 Three Springs Blvd, Durango, CO 81301	**T** 970.403.0182	**F 970.403.0191**
	Crossroads Detox 1125 Three Springs Blvd, Durango, CO 81301	**T** 970.259.8732	**F 970.259.8734**
	Crossroads RCT 1125 Three Springs Blvd. Durango, CO 81301	**T** 970.403.0180	**F 970.403.0190**
	La Plata Integrated Healthcare 1970 E 3rd Ave, Unit 1 Lower Level, Durango, CO 81301	**T** 970.335.2288	**F 970.335.2280**
	Oral Health Clinic 2530 Colorado Ave., Suite A, Durango, CO 81301	**T** 970.335.2442	**F 970.335.2402**
	Archuleta Integrated Healthcare 52 Village Drive, Durango, CO 81147	**T** 970-264-2104	**F 970.264.2108**

Release ☐ From ☐To:

☐ Treating Providers, all current and future, located at: _____

☐ Organization or Agency: _____ Person or Job Title: _____

Mailing Address: _____

City, State, Zip Code: _____

Type of Disclosure Authorized & Delivery Instructions: ☐Mail records to address above ☐Fax records to: _____

☐Call to pick-up records: _____ ☐Email:_____ Other: _____

Treatment Dates:

Dates from:_____ through _____

Purpose of Disclosure: The information may be disclosed for treatment, payment, healthcare operations, and the following purposes

☐At Request of Patient ☐Continuity of Care ☐Legal ☐Insurance ☐Multi-agency Coordination ☐Testimony ☐Other:_____

Type of Information to be Disclosed: ☐Primary Care ☐Mental Health/Psychiatric ☐Substance Use ☐Dental

Protected Health Information to be Disclosed:

☐Attendance	☐ Immunizations	☐ Entire Record
☐Balance/Payment	☐ Lab Results	☐ Other: _____
☐Diagnostic Evaluation/Assessment Update	☐ Medications	_____
☐Discharge Summary	☐ Problem List	_____

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 (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.

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 two years 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 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.

Acknowledgement: 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: 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.

_____ _____

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

(**AHS Use Only**) Signature Verification: ☐Driver's License ☐ Other State-Issued ID or previously signed document in chart

(AHS Use Only) Patient # _____

281 Sawyer Drive, Suite 100, Durango, CO 81303 / Fax# 970-247-7885

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