Authorization to Use and Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 Social Security#	Phone#

I authorize **Axis Health System to disclose/release** the Protected Health Information specified in this request to the organization, agency or individual named. **I also authorize disclosure of my Protected Health Information to Axis Health System by any health care professional, medical facility or other health care provider** that has provided payment, treatment or services to me or on my behalf. ☐ I authorize verbal release only.

Release To:

☐ Individual (name):	Phone#
☐ Treating Provider (name/business name):	Phone#
☐ Organization and Person/Job Title:	Phone#

Method of Delivery:

☐ Encrypted Email - Address: ______________________________________	☐ Fax – Number:_____________________________________
☐ Mail - Address: ____ City State, Zip: ____	☐ Call to pick-up - Phone#: ____________________________ Axis Pick-up Location: _________________________________

Purpose of Disclosure:

☐ At Request of Patient ☐ Continuity of Care ☐ Legal ☐ Insurance ☐ Testimony ☐ Other: _______________________________________

Type of Information:

☐ Primary Care ☐ Mental Health/Psychiatric ☐ Substance Use ☐ Dental

Treatment Dates From:_____________________________________ through____

Information to be Disclosed:

☐ **Pertinent Health Records Only**: Encounter/Progress Notes, Diagnostic Evaluation/Assessment Update, Discharge Summary, Treatment/Service Plan, Laboratory/Pathology/Radiology/Diagnostic Reports

Or Specific Documents:

☐ Attendance	☐ Encounter/Progress Notes or Visit Notes	☐ Treatment/Service Plan
☐ Billing Records	☐ Immunizations	☐ Entire Record
☐ Diagnostic Evaluation/Assessment Update	☐ Lab Results	☐ Problem List
☐ Discharge Summary	☐ Medications	☐ Other: ______________________________

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 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. **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 by the HIPAA Privacy Rule. 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. **Acknowledgement**: 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), acquired immune deficiency syndrome (AIDS) or family planning/contraception. **Right to Revoke**: I understand I may revoke this authorization at any time by submitting my request in writing to the Health Information Management Department. If I revoke this authorization, it will not have any effect on information disclosed prior to Axis Health System receiving the revocation. **Expiration**: Without my written revocation, this authorization expires two (2) years from the date of my signature, unless a different date is specified here: ____________________, whichever occurs first. Copies are as valid as the original.

Signature and Date

Signature: ____ Date:_______________________________________

Patient (*Representative/Parent/Legal Guardian)

*I have legal authority to sign on behalf of the patient; my ability has not been limited/restricted voluntarily or through legal process. Verification of legal documents may be requested.

Relationship (if not patient):____

Name of Individual Signing on Patient's Behalf: ____

AHS Use Only – Patient# ____ Signature Verification: ☐Driver's License ☐ ID/signed document in chart

Staff Assisting with Form Completion: ____

5.15.2020