Record Release Authorization

As required by the Health Insurance Portability and Accountability Act of 1996, Uncompahgre Medical Center may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature in this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

Patient Name: ___________________________________ Date of Birth: _____________

Authorization Section

I, ________________________________ (*print name*) hereby authorize the use and disclosure of the following health information that pertains to me:

*Initial **all** that apply*

______ Medical Health Information
______ Dental Health Information
______ Mental Health Information
______ HIV Testing results and related information
______ Drug and Alcohol diagnosis, treatment or referral information

Please limit information to: ____

____

I authorize the following persons to SEND these disclosures of my health information:

Facility/Person _____________________________________
EMAIL: ____
Address ____
____
Phone # ______________________

☐ *Uncompahgre Medical Center*
1350 Aspen Street
PO Box 280
Norwood, CO 81423
records@umclinic.org
Ph: (970) 327-4233 Fax: (970) 327-4228

I authorize the following persons to RECEIVE these disclosures of my health information

Facility/Person _____________________________________
EMAIL: ____
Address ____
____
Phone # ______________________

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PO Box 280
Norwood, CO 81423
records@umclinic.org
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I authorize the release of information for the following purposes:

Initial One

______ At my request
______ Continuity of Care at another Health Care Facility

Continued on back…

Record Release Authorization (*continued*)

I understand that information in this form is intended to comply with the requirements of 42 CRF 2.31 which restricts the disclosure of information relating to alcohol and drug abuse treatment unless authorized by the patient with CRS 433.045(3) AOR 33312270 consent to HIV test requirements.

I understand that I may revoke this authorization at any time by notifying Uncompahgre Medical Center in writing or signing the revocation section below. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand this authorization will automatically expire in one year from date signed unless another date is added here: ________________.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment or my eligibility for benefits will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that Uncompahgre Medical Center may/may not receive compensation for the uses and disclosures that I have authorized.

______________________________ ______________________________ ______________________________

Signature Phone Number Date

If not signed by the patient, please indicate your relationship to the patient and print your name below:

- ☐ Parent or Guardian
- ☐ Guardian or Conservator
- ☐ Beneficiary or Person Representative

____

Print Name (*if not Patient*)

<u>Revocation Section</u>

I hereby revoke this authorization.

______________________________ ______________________________ ______________________________

Print Name Signature Date