Authorization to Disclose Protected Health Information

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	City, State, and Zip	Telephone Number

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization named herein

Release by:

_____
Facility or Clinic

_____
Address

_____
City, State, and Zip

_____
Phone/Fax Numbers

Release to:

Pediatric Partners of the Southwest
810 E 3rd St., #301
Durango, CO 81301
FAX 970-375-9210

*Please do not fax documents which exceed 10 pages in length

Treatment Dates (approximate): _____

Purpose: ☐ Further Medical Care

Pertinent Protected Health Information Allowed to be Included:

☐ Discharge Summary	☐ Radiology	☐ Special Studies
☐ History & Physical/Consult	☐ Outpatient Record	☐ Medication Records
☐ Operative Report	☐ Progress Notes	☐ Psych Health Records
☐ Labs	☐ Physician Orders	☐ Other (specify): _____

☐ Entire Medical Record

***Psychotherapy Notes are distinct and may not be included with the disclosure of any other protected health information. A Patient Authorization to Disclose Psychotherapy Notes may need to be completed.**

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 revoke this authorization at any time in writing by submitting my request in writing to the designated Health Information Management / Medical Records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original.
I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form. If I have questions about disclosure of my health information, I can contact the designated Corporate Responsibility and Privacy Officer.
Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date specified here: _____
Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and Human Immunodeficiency Viruses (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

Electronic Signature: _____ Date: _____
Patient (if older than 18) or Parent/Legal Guardian: Please type first/last name

☐ I understand that checking this box constitutes a legal signature confirming the above is accurate
In certain circumstances a minor may authorize the release of Protected Health Information, such as mental health or drug/alcohol treatment, or reproductive health

Relationship (if other than patient): _____

For office use only
Number of pages released: _____ Completion date: _____ Delivery Method: _____
Name of individual who received request: _____ Date received: _____

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