

Authorization for Use or Disclosure of Protected Health Information

Behavioral Health

We value your privacy at Northwest Colorado Health. Legally, we cannot release your written health record to anyone (including you) without your specific consent. We need every question on this form answered in order to share your information. We will work on your request as soon as possible, but it may take up to 48 business hours to complete.

About You	Patient Information: Patient Name: _____ Date of Birth: _____ SS# _____ Address: _____ Phone # _____		
Your Medical Records	Request Information FROM: Please populate all known information <input type="checkbox"/> Northwest Colorado Health Name / Agency _____ Phone # _____ Fax # _____ Address _____ City/State _____		
	Release Information TO: Please provide all known information <input type="checkbox"/> Self / Legal Guardian <input type="checkbox"/> Northwest Colorado Health <input type="checkbox"/> Other Name _____ Phone # _____ Fax # _____ Address _____		
	Information to be released: From & To Dates: _____ <input type="checkbox"/> ALL Dates <input type="checkbox"/> Progress Note _____ <input type="checkbox"/> Lab Report _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> NO RECORDS NEED RELEASED		Purpose of Disclosure: <input type="checkbox"/> Second Opinion <input type="checkbox"/> Legal <input type="checkbox"/> Insurance <input type="checkbox"/> School <input type="checkbox"/> Primary Care Provider Change <input type="checkbox"/> Other: _____
Special Situations	I understand that this health information may include information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to: <input type="checkbox"/> Substance Abuse (including alcohol/drug abuse) <input type="checkbox"/> Mental Health <input type="checkbox"/> Psychotherapy Notes <i>I understand that if I also saw a Medical Provider for Substance Abuse a second release is required to be completed for those records.</i> The confidentiality of these records is required Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in this statute. X _____ Signature of Patient, Parent or Legal Guardian Date		
Signature	1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original. 2. I understand that I may revoke this authorization at any time by notifying Northwest Colorado Visiting Nurse Association / Privacy Officer at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it. <p style="margin-left: 20px;">Northwest Colorado Health Attn: Privacy Officer 940 Central Park Drive, Suite 101 Steamboat Springs, CO 80487</p> 3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS – related information, and psychiatric/ mental health information. 4. My health care and payment for my health care will not be affected if I do not sign this form. 5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment. 6. I hereby authorize Northwest Colorado Health to use or disclose my protected health information as indicated. I understand that by my request, I will receive a copy of this form after I sign it.		
<i>By signing below, I acknowledge that I have read and understand this Authorization.</i>			
Signature of Patient Date		Records Received By Date	
Relationship to Patient if not self			