University of Colorado
Colorado Springs

Patient Name(s)

Medical Record #

Date of Birth

Contact Phone #

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Please check if you are requesting information be obtained and /or released by UCCS HealthCircle Clinics.

☐ **Obtain From: (Releasing facility)**	☐ **Release To: (Receiving entity)**

Please check which HealthCircle Clinic(s) apply.

☐ Aging Center (719) 255-8002 (719) 255- 8006 Fax	☐ Center for Active Living (719)255-8004
☐ Peak Nutrition Clinic (719) 255- 7524 (719) 255- 8044 Fax	☐ Primary Care Clinic (719) 255- 8001 (719) 255- 8044 Fax
☐ Veterans Health and Trauma Clinic (719) 255- 8003 (719) 255- 8075 Fax	☐ Helen and Arthur E. Johnson Beth-El College of Nursing and Health Sciences, Nurse-Family Partnership© (719)255-8049

Please check if you are requesting information be obtained and / or released by another provider.

☐ **Obtain From: (Releasing facility)**	☐ **Release To: (Receiving entity)**

Provider Name:____

Address:____

City, State, Zip____

Phone:____

Fax:____

The Purpose for this Release:

- ☐ Continuity of Care
- ☐ Damage/Claim Information
- ☐ Personal Use
- ☐ Legal
- ☐ Coordination of Care
- ☐ Other ________________________

INFORMATION TO BE RELEASED AND / OR OBTAINED (CHECK ALL THAT APPLY):

Date of Service Range (month/year): From:________________ To:_____________________

☐ Emergency Room Report	☐ Mental Health Treatment	☐ Genetic Information
☐ Discharge Summary	☐ Drug/Alcohol Treatment	☐ HIV/AIDS Information
☐ Operative Report	☐ Radiology Reports	☐ Radiology Images
☐ History and Physical	☐ Laboratory Reports	☐ Other: ________________
☐ Clinic/Progress Notes	☐ Immunization Records	______________________

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, and further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and **THERE MAY BE A COST TO COPY THE RECORDS OR WRITE A TREATMENT SUMMARY.**

I understand there are limited exceptions to these provisions in the Colorado Statutes. These require reporting of threats of violence, harm, or child or elder abuse and neglect (from either evidence or suspicion), or when subpoenaed by the courts, to proper authorities. Certain other exceptions exist and will be explained as necessary.

I understand that **this consent expires the sooner of one year from the date of my signature or 6 months from the last appointment** unless otherwise specified as follows: ______________________ I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date of this authorization. A copy, fax, or scan of this form is to be considered as valid as the original.

____	____________________________
Signature of Patient or Authorized Representative	**Date of Signature**
____	____________________________
Printed Name	**Relationship to Patient (if applicable)**

(Please Provide a Copy of This Form to the Patient)

Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated above:

____________________________________	________________________
Signature of Patient or Personal Representative	Date