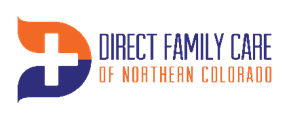
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# (970)632-4931/fax (888)939-4124

1.

**Name of Patient Birth Date**

**Street Address City, State, Zip**

2. **AUTHORIZES:**  3. ***RELEASE* PROTECTED HEALTH**

**INFORMATION TO:**

Direct Family Care of Northern Colorado

## Name of Health Care Provider/Plan/Other Name of Health Care Provider/Plan/Other

126 W. Harvard Ste 1

## Street Address Street Address

Fort Collins, CO 80525

## City, State, Zip Code City, State, Zip Code

1. **INFORMATION TO BE RELEASED:**

* Discharge Summary Lab Results

History & Physical Medication Lists

X-Ray Reports Problem List

Consultations Immunization Records

Physician Progress Notes Other:

List of Allergies

* Physician Orders
* Entire Record

For the following dates:

In compliance with the Colorado Mental Health Procedures Act:

\_\_\_ Copies of medical records pertaining to diagnosis and/or treatment of psychiatric, psychological conditions and/or drug or alcohol abuse may be released to the recipient as noted above.

\_\_\_ Copies of medical records, including information of the diagnosis and/or treatment for AIDS/HIV (including testing) may be released to the recipient as noted above.

5. **PURPOSE FOR NEED OF DISCLOSURE: (Check all that apply)**

\_\_\_ Further Medical Care \_\_\_ Personal

\_\_\_ Insurance Eligibility/Benefits \_\_\_ Changing Physicians

\_\_\_ Legal Investigation or Action \_\_\_ Other (Specify):

6. I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans, or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

1. **Your Rights with Respect to This Authorization:**

* **Right to Receive Copy of This Authorization-** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
* **Right to Refuse to Sign This Authorization-** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment or payment, on my decision to sign this authorization.
* **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Privacy Officer at (610) 530-9155. I am aware that the revocation will not apply to information that has already been released in response to this authorization.

8. **Expiration Date:** This authorization is good until the following date(s) or event(s) (specify event) .

If I fail to specify an expiration date or event, this authorization will expire 90 days from the date on which it was signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

9. **Signature of Patient:**  **Date:**

(If signed by person other than patient, state relationship and authority to do so.)

Patient is: \_\_\_ Minor \_\_\_ Incompetent \_\_\_ Disabled \_\_\_ Deceased

Legal Authority: \_\_\_ Custodial Parent \_\_\_Legal Guardian \_\_\_ Executor of Estate of Deceased

\_\_\_ Power of Attorney for Healthcare \_\_\_ Authorized Legal Representative

**Signature of Witness:**  **Date:**