HIPAA Authorization to Use/Disclose PHI

Patient Name _____ **Date of Birth** _____ **Medical Record #** _____

Section 1: I hereby authorize **Children's Hospital Colorado (CHCO)** to release information, as described below, to:

Name of Individual/Organization **to receive** information: _____

Address: _____

Phone number: _____ Fax number: _____ **For the purpose of**: ☐

Continuing Care/Treatment ☐ Legal ☐ Personal Use ☐ Insurance

☐ Other (please describe): _____

Section 2: Type of records and dates to be released*

☐ Entire Legal Medical Record

☐ Pertinent Legal Medical Records Only [including: Provider Progress Notes and Reports, Emergency Dept. Reports, Discharge Summary, Lab/Pathology reports, Imaging Reports, Operative/Procedure Reports, EKG Report]

Other records:

☐ Telephone Consults	☐ Immunization Record	☐ Nurses Notes	☐ Audiology Tests
☐ Clinical Social Work	☐ ECHO, EEG, EMG, PFT Tests	☐ Genetic Testing	☐ Radiology Images
☐ Drug/Alcohol Treatment	☐ Behavioral Health Records	☐ HIV/AIDS Records	☐ Billing Information

☐ Other: _____

Dates of Services (between): _____ **and** _____

Please Note: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted diseases.

***Patient signature required below to release these department specific records:**

Patient age **13 or older**: Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDS, or drug/alcohol treatment information.

Patient age **12 or older**: Behavioral health or psychiatric care information.

Release method:	☐ Paper	☐ CD *(only available for records stored electronically)*
Delivery method:	☐ Mail	☐ Fax

I understand the following: This authorization will automatically **expire** 1 year from the date signed below or the date the minor child becomes an adult under state law, unless I request an expiration date sooner than 1 year. I may choose to **revoke** this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying CHCO in writing. Information disclosed pursuant to the authorization may be subject to **re-disclosure** by the recipient and is no longer protected by the HIPAA Privacy Rule. I will be provided a copy of this authorization upon fulfillment of the request. CHCO will still provide treatment and seek payment for services provided, whether or not I sign this authorization. CHCO may charge for copies of medical records.

Signature _____ **Date** _____ **Signature of Patient** (when required) _____

☐ Parent or Personal Representative ☐ Power of Attorney ☐ Next of Kin of Deceased ☐ Executor of Estate

CHCO HIM • 13123 E. 16th Ave, Box 150, Aurora, CO 80045 • Ph: 720-777-4259 • Fax: 720-777-7251
CHCO Radiology • Email: radiology.archive@childrenscolorado.org • Ph: 720-777-8625 • Fax: 720-777-7132
ROI @ Briargate • Ph: 719-305-9562 • Fax: 719-305-9702