☐**University of Colorado Hospital**
12401 E. 17th Avenue - Box A025
Aurora, CO 80045
(720) 848-1031 Phone (720) 848-5551 Fax

☐**UCH Psychiatric Services**
(720) 848-6190 Phone (720) 848-5549 Fax

Medical Record #

Patient Name(s)

Date of Birth

Social Security #

Contact Phone #

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

OBTAIN FROM: (Releasing facility)			RELEASE TO: (Receiving entity)		
Name			Name		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

INFORMATION TO BE REVIEWED: **IN ELECTRONIC MEDICAL RECORD ONLY** ☐

DURING PATIENT ADMISSION/VISIT ☐ **IN HEALTH INFORMATION DEPARTMENT** ☐

INFORMATION TO BE PHOTOCOPIED AND RELEASED (CHECK ALL THAT APPLY):

Date of service range (month/year): From:__________________ To:__________________

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

THE PURPOSE FOR THIS RELEASE:

______Continuity of Medical Care ______Damage/Claim Information ______Personal Use ______Legal

Other: __________________

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 that this authorization is voluntary, that further treatment can not be conditioned upon my signing this authorization. I acknowledge that incomplete forms can not be processed and **THAT THERE MAY BE A COST TO COPY THE RECORDS.**

I understand that **this consent expires 180 days from the date of my signature** unless otherwise specified as follows: __________________ I understand that 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 that 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 on 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)

ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS: I hereby acknowledge that I have reviewed/received the medical records from the University of Colorado Hospital on the above named patient.

______ Date ______ Signature ______ Date ______ Witness Signature