Elevated Community Health

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form allows the patient or their legal representative to authorize the release of protected health information (PHI) in accordance with HIPAA regulations to or from a third party. Since this is a legal document, please read it carefully and complete all sections before signing.

PATIENT INFORMATION

Patients Name (first, middle, last)	Date of Birth (mm/dd/yyyy)	Preferred Phone Number
Previous or maiden name if applicable	Address (Street, City, State, Zip)	

PURPOSE OR NEED FOR THIS DISCLOSURE

☐Further Medical Care ☐Attorney ☐Disability ☐Personal Use ☐Insurance ☐Workers Compensation ☐Other, Specify: _____

DATES OF SERVICE TO BE RELEASED

☐Last year ☐Last two years ☐All dates Specific dates **FROM**: _____ **TO**: _____

RELEASE INFORMATION FROM:

☐**Elevated Community Health**
Medical Records Department
PO BOX 4337
Frisco, CO 80443

☐ **Other** (organization, department or individual)
Name: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: _____ Fax: _____
Email address: _____

RELEASE INFORMATION TO:

☐ **Elevated Community Health**
Medical Records Department
PO BOX 4337
Frisco, CO 80443

☐ **Other** (organization, department or individual)
Name: _____
Street: _____
City: _____ State: _____
Zip: _____ Phone: _____ Fax: _____
Email address: _____

INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD (CHECK ALL APPLICABLE BOXES)

☐Medical Note(s) summaries	☐Behavioral Health Note(s) summaries	☐Lab results	☐HIV/AIDS treatment/lab results	☐Genetic testing	☐Sexually transmitted infection
☐Dental note(s)	☐History and physical	☐Immunization records	☐Pathology reports	☐EKG's	☐Radiology reports/image(s)
☐Other, please specify; _____				☐Medication list	☐Billing information

PREFERRED METHOD FOR DELIVERY OF REQUESTED RECORDS

☐Paper copy will be mailed to the requested address above. ☐Paper copy patient/legal guardian will pick up from ECH (Identification required)	☐Fax copy of requested records will be faxed to the fax number above. ☐Electronic copy of records will be emailed to: _____

Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).

- I understand that Elevated Community Health (ECH) will not condition treatment on whether I sign this authorization.
- I may request a copy of the signed authorization.
- I have a right to inspect and receive a copy of the material to be disclosed.

As a healthcare entity, we are required by HIPAA regulations to encrypt our email messaging correspondence to ensure confidentiality. If you choose to receive emails from us, you will be prompted to enter a password before accessing them. We advise you to choose this option of communication only if you are aware of the risks and understand them.

- I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment, payment or enrollment or eligibility for benefits from ECH. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal privacy and/or confidentiality rules.
  - If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my medical record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), and Human Immunodeficiency Virus (HIV), through ECH's general provision of health care.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to ECH. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Signature: _____ Printed Name: _____
(Patient/Legal Guardian) (Printed Name of Patient/Legal Guardian)

Mailing Address: _____ Phone: _____ Date: _____
(Street) (City) (State) (Zip)

ECH Staff: _____ Date: _____ Medical Record #: _____ Records Sent Date: _____