Colorado PHYSICIAN PARTNERS

Authorization/Release for Protected Health Information (PHI)

Patient Last Name	Patient First Name	M. I.	Patient Date of Birth

Street Address	City	State	Zip Code

Cell Phone	Home Phone	Email Address

I hereby authorize the following facility to disclose Protected Health Information (PHI) of the Patient listed above:

From: *Internal Medicine Southwest*

Address: *6169 S. Balsam Way, Suite 190 Littleton, CO 80123*

Phone #: *(303) 933-8240* Fax #: *(303) 933-8204*

To: _____

Address: _____

Phone #: _____ Fax #: _____

Reason to Release Protect Health Information (PHI): _____

Specific Date Range: ☐ All Dates **OR** ☐ Only From: _____ To: _____

Type of Records: ☐ Complete Records **OR** ☐ Partial Records: _____

Substance Use Disorder (SUD) Records: ☐ YES **OR** ☐ NO (please exclude from 'Complete Records')

* The Federal rules restrict any use of the information to criminally investigate or prosecute any patient with a diagnosis of SUD. Substance use disorder means cognitive, behavioral, and physiological symptoms indicating that the individual continues using substance despite significant substance-related problems such as impaired control, social impairment, risky use, and pharmacological tolerance and withdrawal; substance use may include drug and/or alcohol; does not include tobacco or caffeine use (Federal Confidentiality of Substance Use Disorder Patient Records rule (42 CFR Part 2)

Expiration: This authorization will expire (check one): ☐ Fulfillment of the Request **OR** ☐ Date: _____

If no expiration date entered, this release will expire upon completion of this record request*

I acknowledge, and hereby consent to such, that the released information may contain sensitive information such substance abuse, STD, HIV, AIDS, genetic testing, and mental health information. I understand that this authorization may be revoked by me, in writing, at any time, except to the extent that action has been taken in reliance upon it. I understand that I do not have to sign this authorization to obtain healthcare benefits for treatment. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the term Complete Record for release of Protected Health Information (PHI) mean that only records generated by this facility will be released. I understand there may be a fee involved with fulfillment of this request. See schedule below.

I have read the above and authorize the disclosure of the Protected Health Information (PHI).

Patient/Representative Signature	Printed Name	Date

Relationship to Patient	Patient Other Legal Name(s) or Also Known As

*Fees for duplication of PHI being released directly to the patient will be charged the following per Colorado law C.R.S. 25-1-801: $18.53 for the first ten pages; $0.85 pages 11-40; each additional page after page 40 is $0.57 per page. Actual postage or shipping costs and applicable sales tax, if any, may be charged. Records may be requested and released by attorney and follow Colorado State Statute rates. To ensure timely processing of medical records, please fill authorization out completely.