EPMC

Estes Park Medical Center, 555 Prospect Ave, Estes Park, CO 80517

AUTHORIZATION FOR DISCLOSURE OF PHI

Estes Park Medical Center/Prospect Park Living Center/Estes Park Home Care & Hospice is requesting your authorization to Use or Disclose your health information. The following is information about the health information at issue, to whom it will be Disclosed, how we will otherwise Use or Disclose your health information if you sign this form and your rights with regard to this Authorization.

DATE_____ **MEDICAL RECORD NO.** _____ **ADMISSION NO.** _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I am the ____Patient____Guardian____Conservator____Designee ____ Surrogate decision maker with authority to use and disclose PHI. _____ Patient's Designated Representative, and I hereby authorize EPMC/PPLC, Estes Park Home Care & Hospice to disclose to (name and address of person, organization, or agency): _____

_____

_____

Date(s) of service to be released:_____. This authorization is valid for a period of one year and can be revoked by me at any time before then. I understand that the request for revocation must be in writing and is effective when received by the Health Information Management Department at EPMC. **Exceptions To Right of Revocation:** I understand that my written revocation will not affect the ability of EPMC/PPLC/EPHCH to continue to Use or Disclose my health information to the extent that it has already acted in reliance on this Authorization. For example, EPMC/PPLC/EPHCH cannot rescind disclosures it has already made, and may Use my health information as necessary to bill and collect for services rendered. **Prohibition on conditioning of authorization:** EPMC/ PPLC/EPHCH cannot condition treatment on your signing this authorization, unless: You are receiving research-related treatment; or the only reason EPMC/ PPLC/EPHCH is providing you with health care is to make a report to a third party, such as your employer.

Please mark information to be released:

____	Discharge Summary	____	Face Sheet
____	History and Physical	____	Laboratory Results
____	Emergency Department Record	____	Interdisciplinary Care Plan
____	X-Ray Reports	____	Operative Report
____	X-Ray Film #_____		
___	Other, please specify _____		

It is the policy of Estes Park Medical Center/Prospect Park Living Center/Estes Park Home Care & Hospice to require a current specific authorization to release the types of information listed below. As a result, if such information is contained in this patient's records, that information has not been released to you at this time unless authorized below. Alcohol/Drug treatment records are protected by federal regulation 42 CFR, part 2 and must be specifically authorized by either the patient or his representative.

SPECIFIC AUTHORIZATION: Mental Health Information ___ Drug/Alcohol Information ___ AIDS/HIV Testing ___

I understand that upon release of this information, EPMC/PPLC/EPHCH will no longer guarantee the confidentiality of the information contained in my medical record. I release the EPMC/PPLC/EPHCH, the attending physician, and all hospital personnel from any and all liability concerning the release of this information. I understand that this original form will become a permanent part of my EPMC/PPLC/EPHCH medical record. I also understand that a copy of this form may be mailed or faxed to the entity named above for the release of medical records to EPMC/PPLC/EPHCH.

_____ _____ _____ _____

Patient's Signature Date Legal Decision Maker Signature Date

_____ _____

Witness Signature Date

Copied information delivered by means of: _____ hand delivery _____mailed _____faxed _____ _____

(initial) (date)

NOTE: EPMC has a minimum charge of $16.50 for the first 10 pages copied plus $0.75 for pages 11-40 and $0.50 for each additional copy thereafter. There will be no charge for information sent from EPMC/PPLC to an insurance company for billing purposes. There will be no charge for information sent to a physician's office unless it exceeds 75 pages.