Boulder Community Health
Ambulatory Services Department

HIPAA Release of Medical Information from BCH

Patient's Name: _____ **DOB**: _____

INFORMATION RELEASE TO OTHER PERSONS AUTHORIZATION: I authorize the release of any of my medical information either over the phone or through the MyBCH Clinic Patient Portal, to the following individuals:

1. _____ Relationship: _____
2. _____ Relationship: _____

RELEASE RECORDS ☐ **To** ☐ **From** ☐ **To** ☐ **From**

Clinic Address Stamp

Name:_____

Phone:
_____

Address:
_____

_____

Fax:
_____

GENERAL AUTHORIZATION: I authorize the above-named health care provider to release the information specified below to the organization/agency/individual named on this request. Method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication by appropriate practitioner.
I understand that BCH may not refuse to provide treatment if I refuse to sign this authorization, unless this authorization is necessary to participate in a research study or if the purpose of the treatment is to provide information to the party listed in this authorization. I understand that except for drug and alcohol treatment records, information disclosed under this authorization may be re-disclosed by the recipient and is no longer protected by privacy laws.

SPECIFIC AUTHORIZATION: I specifically authorize the release of information regarding the following conditions:

- ☐ Alcohol/Drug abuse information – I understand that my chemical dependency records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CRF, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (see reverse side for re-disclosure prohibition)
- ☐ Psychosocial/ Psychiatric information: (excludes psychotherapy notes which require separate release)
- ☐ Other: _____

INFORMATION REQUESTED:

- ☐ Complete copy of medical record (most recent 2 years)
- ☐ History and physical exam
- ☐ Discharge summary
- ☐ Treatment plan
- ☐ Admitting psychiatric assessment
- ☐ Emergency department record
- ☐ Other _____
- ☐ Operative reports, consults
- ☐ Laboratory reports
- ☐ Imaging reports
- ☐ EKG
- ☐ EEG
- ☐ Providers orders & progress notes
- ☐ Nurses' notes
- ☐ Therapy notes & dictation
- ☐ Psychological eval (excludes psychotherapy notes)
- ☐ Neuropsych/Psych. testing & evals (does not include raw data or psychotherapy notes)

CONDITIONS AND DATES OF CARE COVERED:

- ☐ Regarding these treatment dates and/or for conditions: _____
- ☐ All admissions or care at this facility provided as of the date of my signature:

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PURPOSE(S) FOR WHICH INFORMATION IS TO BE USED:

- ☐ Further eval/treatment
- ☐ Insurance/reimbursement
- ☐ Legal
- ☐ Verify Treatment Status
- ☐ Personal use
- ☐ Worker's Compensation
- ☐ Other (specify) _____

EXPIRATION OR REVOCATION OF AUTHORIZATION:

I understand that I may revoke this authorization at any time, except to the extent that action has already been take to comply with it. Without my previous expressed revocation, this authorization will automatically expire one year from the date of my signature unless noted below.

- ☐ On _____
- ☐ No longer than _____ days from the date of my signature or under the following conditions: _____
- ☐ Upon fulfilling the purpose or need for information as specified above, but no longer than _____ days from the date of my signature.
- ☐

NOTE: Federal regulations require consent to release alcohol or drug records last no longer than reasonably necessary to serve the purpose for which the release is given.

SIGNATURE: A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.

Patient's Signature (if 18 years of age or older) _____ Date: _____

If patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

Authorized Representative Name (please print): _____

Authorized Representative Signature: _____ Date: _____

Witness Name: _____ Signature: _____ Date: _____

In accordance with 42 C.F.R. Section 2.13 , any disclosure of information from a federally assisted drug or alcohol abuse program must be limited to that information which is necessary to carry out the purpose of disclosure.

Pursuant to 42 C.F.R. Section 2.32, the following statement on the prohibition of re-disclosure must accompany each disclosure made with the patient's written consent:

Prohibition on Re-disclosure

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2) The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Regulations for patient medical record reproduction fees

Standards for hospital and health facilities 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4; Adopted by the Board of Health on May 16, 2001; Effective June 30, 2001 The discharged patient or representative shall pay for the reasonable cost of obtaining a copy of his/her patient record.

Updated 3/2015