AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

COLORADO PLAINS MEDICAL CENTER

I hereby authorize and request:

Colorado Plains Medical Center
1000 Lincoln Street
Fort Morgan, CO 80701

To furnish protected health information of:

Name of Patient (Please Print): _____
Last First MI Previous Name If Any

DOB: _____ Social Security #:_____ Telephone: _____
Address: _____
Street City State Zip Code
Covering the periods of healthcare (date(s) of Service): from (date) _____ to _____,
To disclose to (name/address): _____

I request the release of the specific categories of information that I have **initialed** below:

- ☐ _____ Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV) infection
- ☐ _____ Diagnosis and/or treatment relating to drug or alcohol abuse
- ☐ _____ Diagnosis and/or treatment relating to mental health conditions
- ☐ _____ Confidential details of:
  - ☐ Psychotherapy Notes (Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist)
  - ☐ Social Work Counseling/Therapy ☐ Discharge Summary ☐ Lab Reports
  - ☐ Operative Reports ☐ Pathology Reports ☐ Imaging Reports ☐ Orders/Progress Notes
  - ☐ H&P and Consultation(s) ☐ Other: _____

The purpose of this disclosure is:

- ☐ Medical Care ☐ Legal Matter ☐ Insurance ☐ Personal
- ☐ Other (please specify) _____

- I may refuse to sign this authorization and my refusal will have no impact on receiving treatment.
- I can inspect or copy any information disclosed under this agreement.
- I have voluntarily signed this document.
- I can revoke this authorization at any time and the revocation must be in writing.
- I understand that the revocation will not apply to information that has already been released.
- I will receive a copy of this authorization if requested.
- The federal privacy laws will not cover the information released.
- Copies of the records may be obtained with reasonable notice and payment of copying cost.
- I understand this authorization will **automatically expire** from the date indicated below.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about or medical records of, my condition to those persons or agencies listed above.

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ _____ Date: _____

Print Name: _____ Relationship of representative to patient: _____
(When the patient is a minor, or is not competent to give consent, the signature of parent, guardian, or other legal representative required).

Witness Signature: _____ Date: _____

For Internal Use Only

Information Released/Reviewed by: _____ Date: _____