Colorado Mountain Medical
Doctors you know and trust.
A partner of Vail Health

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AUTHORIZATION FOR THE RELEASE OF PATIENT PROTECTED HEALTH INFORMATION TO A THIRD PARTY

Patient Name: _____ **Date of Birth:** _____

I authorize **Colorado Mountain Medical** to disclose my protected health information* to _____

Relationship to patient: _____ Phone: _____

For the purpose of:

☐ Continuity of Medical Care ☐ Damage/Claim Information ☐ Personal ☐ Other:_____

***I understand that my medical records/protected health information may contain information concerning my mental health and/ or psychiatric treatment, drug and/or alcohol treatment as well as any HIV test results (AIDS).**

☐ Authorize Release ☐ Do **NOT** Authorize Release ☐ Not applicable

INFORMATION TO BE RELEASED

☐ I authorize the above named individual(s) or facility to verbally speak with Colorado Mountain Medical regarding my protected health information (PHI), and have access to, **ALL information** in my PHI record.

OR

☐ I authorize the above named individual(s) or facility to verbally speak with Colorado Mountain Medical regarding my protected health information (PHI), and have access to, **only the following information:**

Date of Service range (month/year): From: _____/_____ ☐ All Past
To: _____/_____ ☐ 1 year from date of signature

☐ Emergency Room Report	☐ Mental Health Treatment	☐ Immunization Records (☐ CO State ☐ CMM Clinic)
☐ Discharge Summary	☐ Drug/Alcohol Treatment	☐ Genetic Testing
☐ Operative Report	☐ Radiology Reports	☐ HIV/AIDS
☐ History & Physical	☐ Laboratory Reports	☐ Billing
☐ Clinic/Progress Notes	☐ Other Test Results	☐ Other:_____

Authorization for the use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Colorado Mountain Medical, PC may not use or disclosure your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating a separate revocation form and returning the form to this office.

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above; I understand that once this information is disclosed, it may no long be protected by Colorado Mountain Medical. I understand that this authorization is voluntary, that further treatment can not be conditioned upon signing this authorization and that there may be a cost to copy records. I hereby recognize that providing an e-signature that this complies with the Federal Electronic Signatures in Global and National Comer Act (ESIGN Act) and the Uniform Electronic Transaction Act (UETA). Colorado Mountain Medical implements a two-step verification process to allow e-signatures on this legally enforced authorization. E-signatures must be dated, otherwise it will not be accepted, the signatory may request printed copy of the document at any time. Electronic signatures are not accepted for behavioral/mental health records.

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 360 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

_____ _____
Signature of Patient or Authorized Representative **Date of Signature**

_____ _____
Printed Name **Relationship to Patient (if applicable)**