Salud Family Health

❑ ROI to Send Records	❑ ROI for Verbal communication only
Account Number	Date MM / DD/YYYY

Staff Use Only

HEALTH INFORMATION RELEASE

Instructions: This form is to be used by a patient or legal representative to authorize the release of information to a third party.

Print clearly; each section needs to be completed to be valid.

1. Patient Information

Patient's Name *(First, Middle, Last)*	Date of Birth *(mm/dd/yyyy)*
Previous or Maiden Name *(if applies)* *(First, Middle, Last)*	Preferred Phone number
Patient Address *(Street, City, State, ZIP Code)*	

2. Release Purpose

Check appropriate box or write in other purpose

☐Personal ☐Disability ☐Care Management ☐Payment ☐Legal ☐Workers' compensation

☐Other, specify:

3. Release Information FROM

Check one box and complete if applicable

❑ **Salud Family Health**
Medical Records Department
203 S Rollie Ave. Fort Lupton CO 80621
Fax: 303-227-6426

❑ Other, specify organization, department, or individual *(complete each line below)*

Name_____

Street _____

City _____State_____

ZIP Code _____ Phone _____

Fax_____

4. Release Information TO

Check one box and complete each line for box checked

❑ **Salud Family Health**
Medical Records Department
203 S Rollie Ave. Fort Lupton CO 80621
Fax: 303-227-6426

❑ Other, specify organization, department, or individual *(complete each line below)*

Name_____

Street _____

City _____State_____

ZIP Code _____ Phone _____

Fax_____

5. Delivery of Information

Preferred method for delivery of records:

❑Paper Copy Records will be mailed to the requested address above.

❑ Electronic Copy Email address:_____
(See confidentiality specifications below)

❑ Fax (number listed above in section 4)

HEALTH INFORMATION RELEASE
continued

Patient Name	First, Middle, Last
Birth Date	MM / DD/YYYY

6. Records to Be Released

Timeframe to Be Released: ❑ **Last 2 years** ❑ **Last year** ❑ **All dates**

Dates **FROM:** *(mm/dd/yyyy)* _____ **TO:** *(mm/dd/yyyy)* _____

Document/Note(s) (check all that apply)

- ❑ Behavioral Health/Mental/Psychological notes
- ❑ Medical Provider notes
- ❑ Last Physical Exam
- ❑ Last Dental Exam
- ❑ Dental Notes
- ❑ Other, specify _____

I understand the information to be released may include behavior and/or mental health care, and HIV test results.

Additional Records (check all that apply)

- ❑ Immunizations
- ❑ Laboratory results
- ❑ Pathology report(s)
- ❑ Radiology image(s), specify exam(s)/body part(s)
- ❑ Medication list
- ❑ HIV lab test results
- ❑ EKG(s)/Cardio/Echo
- ❑ Dental Images
- ❑ Billing Information
- ❑ Genetic testing
- ❑ Radiology report(s)

Substance Abuse and Addiction Treatment Records (check all that apply)

- ❑ Assessment/Evaluation
- ❑ Family participation invitation
- ❑ Multidisciplinary notes
- ❑ Treatment plans
- ❑ Other, specify _____

Other, specify if applicable _____

7. Signature and Date *The patient or legal representative must sign and date this authorization.*

- This authorization may be revoked at any time by providing a written notice of revocation to the Medical Records Department if it has not already been released.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I understand that Salud Family Health will not condition treatment on whether I sign this authorization.
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.
- As a healthcare entity, we are required by HIPAA regulations to encrypt our email messaging correspondence to ensure confidentiality. If you choose to receive emails from us, you will be prompted to enter a password before accessing them. We advise you to choose this option of communication only if you are aware of the risks and understand them.
- **I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment, payment or enrollment or eligibility for benefits from Salud. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy and/or confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV), through Salud's general provision of health care. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Salud Family Health. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
- This authorization will expire in 1 year from date of signature unless another sooner date is specified here: _____

SIGNATURE *(required)* ➤	**DATE** *(required)* *(mm/dd/yyyy)*

Printed Name *of Person Signing* ***(If not the patient)***

NOTE: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Relationship if you are not the patient *(legal documentation of the right of access by the signing individual may be required)*

❑ Parent ❑ Stepparent Legal Guardian ❑ Foster Parent ❑ HealthCare Power of attorney ❑ Other _____