



HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's name _____ DOB _____

- Release from / Release to options including Boulder Community Hospital, Foothills Hospital, Mapleton Center, and Community Medical Center.

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.

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...

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 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations (See reverse side for redisclosure prohibition)
Psychosocial / Psychiatric information (excludes psychotherapy notes which require separate release)
Other _____

INFORMATION REQUESTED:

- Complete copy of medical record
History and physical exam
Discharge summary
Treatment plan
Admitting Psychiatric Assessment
Emergency Department record
Other: _____
Operative reports, consults
Laboratory reports
Imaging reports
EKG
EEG
Physician's 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

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 taken to comply with it. Without my previous expressed revocation, this authorization will automatically expire 90 days 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 _____ Date _____

Authorized representative name (please print) _____ Relationship to patient _____

Authorized representative signature _____ Date _____

Witness _____ 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 the disclosure.

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

PROHIBITION ON REDISCLOSURE

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.