Request for Tri-County Health Department to *RELEASE and/or OBTAIN* Medical Records, Health or Personal Information

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE

I, (*Client Name*): ____ **TCHD Medical Record No.** ______________________

Address:_________________________________ **City:** __________________ **State:** ______ **Zip Code:** ____________

Phone #: _______________________ **Date of Birth:** _____/____/____ **SSN #:** ______________________________________

Authorize *(Circle appropriate clinic address)*

4201 E. 72nd Ave Commerce City, CO 80022 P: 303 288-6816 F: 303 439-5996	7000 North Broadway #400 Denver, CO 80221 P: 303 439-5980 F: 720 200-1681	1401 W 122nd Ave Suite 200 Westminster, CO 80234 P: 303 452-9547 F: 303 452-9712	4857 S. Broadway Englewood, CO 80113 P: 303 783-7140 F: 303 761-0851	15400 E 14th Pl #309 Aurora, CO 80011 P: 303 341-9370 F: 303 367-2597	410 S Wilcox Street, Castle Rock, Co 80104 P: 303 663-7650 F: 303 688-3922	9350 Heritage Hills Cir Lone Tree, CO 80124 P: 303 784-7860 F: 303 662-0103	15192 E. Hampden Ave. Aurora, CO 80014 P: 303 745-5858 F: 303 745-3365	6162 S. Willow Dr., Suite 100 Greenwood Village, CO 80111 P: 303 220-9200 F: 720 200-1487

To ______ **Release written or verbal information to (initial indicates consent)**

______ **Obtain written or verbal information from (initial indicates consent)**

Care Provider: ___________________	**Care Provider:** ___________________	**Care Provider:** ___________________
Address: ___________________	**Address:** ___________________	**Address:** ___________________
Phone #: __________ **Fax #:** __________	**Phone #:** __________ **Fax #:** __________	**Phone #:** __________ **Fax #:** __________
City: __________ **State:** ____ **Zip:** ______	**City:** __________ **State:** ____ **Zip:** ______	**City:** __________ **State:** ____ **Zip:** ______

For the purpose of: ____

Dates: From ____________**to**___________ ***(specify dates where appropriate)***

Type: ☐ **Entire Medical Record** ☐ **Most recent 3 yrs of Medical Record** ☐ **Immunizations**
☐ **Laboratory Reports** ☐ **Mammogram films/reports** ☐ **Pap result** ☐ **STI/HIV Testing Results**
☐ **OTHER**____

*****If this authorization is for PSYCHOTHERAPY NOTES, MENTAL HEALTH OR DRUG & ALCOHOL records or information, this release can not authorize the use or release of any other type of protected health information*****

Check here to authorize the release of these records and include dates if applicable:

☐Psychotherapy notes ☐Mental Health Records ☐ Drug &Alcohol Records
From: __________to _________ From: _________to _________ From: _________to_________

Please initial:

1. ____I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

2. ____I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

3. ____I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. TCHD cannot condition treatment, payment, enrollment in the health plan, or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. 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 confidentiality rules.

4. ____I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents if $14.00 for the first ten pages, $.50 per page for pages 11 through 40 and $.33 per page for each page over 40. Shipping and applicable sales tax will also be charged. There is no charge for records sent to another health care provider.

____ ______________________
(Signature of Individual or Authorized Personal Representative) Date

____ ______________________
(Personal Representative's Name (print) and Relationship) Date

Client provided identification: ☐

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.