

1420 Austin Bluffs Parkway

Colorado Springs, CO 80918

Phone: (719) 255-4444

Fax: (719) 255-4446

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check one**: □ Current Student or □ Former Student (Year Graduated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Please check one** and provide the requested information:

□ I hereby authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to disclose

my health information to the UCCS Wellness Center. Please fax records to: **(719) 255-4446**

□ I hereby authorize UCCS Wellness Center to disclose my health information to the following:

Name/ Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_

Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above information will be used/disclosed for the following purposes:

□ Patient Review □ Continuation of Care □ Payment of Claim □ Attorney Request

□ Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I agree that a copy of this release or electronic or faxed submission of this release shall be as valid as this original release.

 This authorization expires in one year (365 days) or\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (list specific date, if less than one year).

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use: D

**The following information is to be disclosed**:

□ Verbal Communication between individuals/offices □ Entire medical record

□ Women’s Health/ Pap Results □ Lab results

□ X-ray and imaging reports □ Prescriptions

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Immunizations

I understand that the information in my health record may include information relating to sexually transmitted, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol or drug abuse**. I authorize the UCCS Wellness Center to disclose any of the following information:**

□ Sexually transmitted diseases □ AIDS/HIV □ Alcohol/Drug abuse □ Behavioral/Mental health

REVOCATION: I understand that I have the right to revoke (withdraw) this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present the written withdrawal to the entity that I have authorized to release this information. I understand that revocation will not apply to information that has already been released in response to this authorization.

RE-DISCLOSURE: I understand that authorizing the disclosure of health information is voluntary and that I am entitled to a copy of this authorization and acknowledge receipt of a copy thereof. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure by the person(s) or “practice/facility” to which it has been disclosed, and the information may not be protected by federal confidentiality.