Eastern Plains Medical Clinic of Calhan
560 Crystola Street * P.O. Box 275
Calhan, CO 80808
(719)347-0100 (o) * (719)347-0851 (f)

Patient Authorization to Disclose Protected Health Information

_____ _____ _____
Patient Name Date of Birth Phone

The above listed patient authorizes the following healthcare facility or physician to make medical record disclosure:

Release **FROM**:		Release **TO**:	**Eastern Plains Medical Clinic**
Address:		Address:	PO Box 275 * 560 Crystola Street
			Calhan, CO 80808
Phone:		Phone:	719-347-0100
Fax:		Fax:	719-347-0851

☐ **PLEASE MAIL RECORDS**

Dates and Type of Information to Disclose:
☐2 years prior to last date seen
☐Specific Dates: _____
☐Specific Information: _____
_____

☐ **PLEASE FAX RECORDS**

Purpose for Disclosure:
☐Change of Insurance or Provider
☐Continuation of Care
☐ Referral
☐ Other _____

I understand I may 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 the health information management department. 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. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date signed.** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing authorization for release of information and do here by acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
Signature of Patient/Parent/Guardian or Authorized Representative Date

_____ _____
Printed Name of Authorized Representative Relationship to Patient