



Dear Requestor,

Please find the attached Authorization form for Use And Disclosure of Protected Health Information. To expedite your request, please follow these guidelines when completing the authorization form:

- Include the **patient's FULL LEGAL name**, and any previous names used
- Include **patient date of birth (DOB)**
- Include **patient Social Security Number** (optional)
- Include **patient address and phone number**
- Indicate **WHO** you would like the healthcare facility to release the requested records **TO**. Include the complete name, mailing address, and phone number of the entity to receive the information
- Indicate the dates of treatment for the requested records
- Indicate **WHAT** records are being requested
- Sign and date** the form (The patient or authorized representative must sign)

Charges for Copies of Records

- There is **NO** charge for records that are sent directly to another healthcare provider
- For patient access, the charge is \$0.10 per page of records copied

Please note that **ALL** elements must be completed on this form, **as it is a legal document**. Should you have questions on this form, please don't hesitate to contact the Release of Information Department.

Please Mail, Fax or drop off your request at Health Information.

Address:

Fax: 303-788-4303

Phone: 303-788-6071

Swedish Medical Center

Attention: HIM

501 E Hampden Ave

Englewood, CO 80113

Billing Requests call (866)475-1385

Radiology Films call 303-788-6057

Patient Information	Patient Legal Name _____ Birthdate _____ SS # _____
	Address/City/State/Zip _____
	Telephone number: _____ Unit Number: _____

Release From:	I hereby authorize: <input type="checkbox"/> The Medical Center of Aurora <input type="checkbox"/> Rose Medical Center <input type="checkbox"/> Centennial Medical Plaza <input type="checkbox"/> North Suburban Med Center <input type="checkbox"/> Presbyterian/St. Luke's Med Center <input type="checkbox"/> Sky Ridge Medical Center <input type="checkbox"/> Spalding Rehabilitation Hospital <input type="checkbox"/> Swedish Medical Center <input type="checkbox"/> Other _____ <input type="checkbox"/> Swedish Southwest ER	Release To:	_____
			Name /Title /Organization _____ Address / City / State / Zip _____ Telephone # _____ Fax # _____

Purpose	<input type="checkbox"/> Continuation of Care <input type="checkbox"/> Insurance or Worker's Comp <input type="checkbox"/> Legal <input type="checkbox"/> Personal Use Other _____ For treatment date(s): _____
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Access Requested:	<input type="checkbox"/> Copies of the record <input type="checkbox"/> Inspection of the record	Pertinent Info:	<input type="checkbox"/> D/C Summary <input type="checkbox"/> H&P <input type="checkbox"/> Consult/Operative Report <input type="checkbox"/> Lab/Radiology <input type="checkbox"/> Emergency Room Record	Selected Portions:	<input type="checkbox"/> Outpatient Visit <input type="checkbox"/> Behavioral Health Record <input type="checkbox"/> Special Studies <input type="checkbox"/> Entire Medical Record <input type="checkbox"/> Physician Orders <input type="checkbox"/> Billing Record <input type="checkbox"/> Medication Record <input type="checkbox"/> Other _____
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Patient Authorization:	ACKNOWLEDGEMENT: I request and authorize the above-named health care provider to release the information specified above to the organization or individual named on this request. I understand that the information to be released may include information regarding the following condition(s): Sickle Cell Anemia; Genetic testing; Human Immunodeficiency Virus (HIV); Drug Abuse, Alcoholism, Alcohol Abuse, if any; Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any
	I understand that: 1. My signature on this form is strictly voluntary. 2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy of Practices. 3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. 4. Fees/charges will comply with all laws and regulations applicable to release of information.

Fees:	Note: HealthOne may charge a fee for copies of the medical records in accordance to Colorado State Law.
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Phys Concurrence: if Applicable:	PHYSICIAN CONCURRENCE FOR PATIENT ACCESS: _____ has my permission to (inspect) (receive copies of) the requested medical records. I have reviewed the medical record(s) and have determined they (do) (do not) contain information relative to psychological or psychiatric problems, which, if revealed to the patient, could be harmful to the patient's well being.
	Attending physician or designee _____ Date _____

Delivery Instructions:	<input type="checkbox"/> Call requestor for pick-up when records are ready. <input type="checkbox"/> Mail records directly to person or organization specified.	Confirmation of PICK-UP _____
	<input type="checkbox"/> I authorize _____ to pick up my Protected Health Information (PHI). (Print Name)	Signature _____
	Relationship _____	Date _____

Signature:	My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.
	Date _____ Patient or Authorized Representative _____ Relationship to Patient _____ A copy is provided after signature.

EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified as follows: _____

OTHER CONDITIONS: A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.



Authorization for Use and Disclosure of Protected Health Information (PHI)

HealthONE USE ONLY	
Verification:	
Date Authorization Received: _____	By: _____
Date Request Completed: _____	By: _____
Identification/Driver's License # Verified: _____	
<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other _____	