Pueblo Community Health Center
Your Health. Our Mission.

Authorization for the Use or Disclose of Protected Health Information

Patient Name: _____DOB: _____Medical Record #_____

Address: _____

Telephone #_____E-mail Address_____

I, _____, authorize **Pueblo Community Health Center, Inc.,** to **Release / Receive** medical records
(Patient or Legal Representative) (Circle One)

To / From (Circle One)

Name: _____Phone: _____

Address: _____

Only the following specific information: Other _____ Date(s) of Service: _____
Or:

☐ Entire Medical Record and for specified date(s) of service: From: _____ To: _____
("Present" equals date of signature)

☐ Behavioral Health and for specified dates(s) of service: From: _____ To: _____
("Present" equals date of signature)

☐ Dental and for specified dates(s) of service: From: _____ To: _____
("Present" equals date of signature)

Information to be released by: ☐ Paper ☐ Electronic

I understand that information disclosed pursuant to this authorization may include information relating to the following, **unless specifically restricted below:**

- Psychological / psychiatric conditions
- HIV/AIDS diagnosis and/or testing
- Genetic testing
- Drug and/or alcohol abuse diagnosis and/or treatment
- Sexually transmitted disease(s) diagnosis and/or testing

List any restrictions: _____

The purpose of the disclosure is: _____

Re-disclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Expiration Date: This authorization is in effect until _____ (I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year.)

Signature of Patient or Legal Representative(s): _____ **Date:** _____/_____/_____
(Note: If patient is a minor child, both parents may be required to sign)

Printed Name(s): _____Relationship to Patient: _____
(if signed by other than patient)

MR Clerk_____