National Jewish Health
Breathing Science is Life.

Authorization to Release Protected Health Information

Full Name ______________________ Medical Record # ____________

Address ______________________

City ____________ State ____________ Zip ________

Phone # ____________ Date of Birth ____________

I hereby authorize:

☐ NJH - Medical Records Dept, 1400 Jackson St, Denver, CO 80206 PH (303) 398-1580; FAX (303) 398-1211; or FAX (303) 398-1987

☐ Other: ______________________

Name/Title Organization

Address

City/State/Zip Phone Fax

Release to:

☐ NJH - Medical Records Dept, 1400 Jackson St, Denver, CO 80206 PH (303) 398-1580; FAX (303) 398-1211; or FAX (303) 398-1987

☐ Other: ______________________

Name/Title Organization

Address

City/State/Zip Phone Fax

☐ Other: ______________________

Name/Title Organization

Address

City/State/Zip Phone Fax

Purpose:

☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal Use ☐ Other ____________

For Treatment Date(s) ____________

☐ Clinic Summary/Consultation ☐ Procedure ☐ Laboratory/Radiology ☐ Pulmonary Test ☐ Cardiology Test

☐ Radiology Images

☐ Other ____________

PLEASE ALLOW AT LEAST 14 DAYS FOR MEDICAL RECORDS TO BE RELEASED FROM OUR OFFICE

Pages	1-10	11-40	41+	According to Colorado Revised Statutes, 25-1-801 the following fees may be charged for copies of medical records.
Others	$18.53	.85 each	.57 each	Records will be provided to other health care providers at no charge.

_____By **initialing** this area, I authorize the release of my health records that may include information indicating the presence of communicable or venereal diseases, which may include, but are not limited to: hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS or Human Immune Deficiency Virus (HIV).

_____By **initialing** this area, I authorize the release of my health records that may include information about behavioral and/or mental health services and/or treatment for alcohol and/or drug abuse.

This request is made voluntarily and the information given is accurate to the best of my knowledge.

I may revoke this authorization at any time in writing, but if I do, it will have no effect on actions taken prior to receiving the revocation.

I understand that information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA privacy rule.

Without my express revocation, this consent will automatically expire 180 days from the date signed below, unless I request an expiration date less than 180 days.

My signature is required to validate this Authorization. If I sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

Patient or Authorized Representative Signature Date Relationship