National Jewish Health®

Authorization to Release Protected Health Information National Jewish Health Information Management Department-Release of Information

1400 Jackson St, Denver, CO 80206 PH (303) 398-1580; FAX (303) 398-1211 or FAX (303) 398-1987

Section A

Full Name _____ Medical Record # _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Date of Birth _____

Section B

I hereby authorize: ☐ National Jewish Health

☐ Other: _____

Name/Title Organization

Address

City/State/Zip Phone Fax

Section C

Recipient(s): ☐ National Jewish Health

☐ Other: _____

Name/Title Organization

Address

City/State/Zip Phone Fax

☐ Other: _____

Name/Title Organization

Address

City/State/Zip Phone Fax

Section D

Purpose of disclosure: ☐ Continuation of Care ☐ Insurance ☐ Legal ☐ Personal Use

☐ Other: **Authorization Expiration Date:**

Description of Information to be Used or Disclosed:

For Treatment Date(s) _____

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

☐ Radiology Images ☐ Other: _____

Request Delivery (If left blank, a paper copy will be provided:

☐ Paper Copy ☐ Electronic Media, if available (CD/DVD)

☐ **Encrypted Email**

☐ **Unencrypted Email** _____

☐ @yahoo.com ☐ @gmail.com ☐ Other: @

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Pages	1-10	11-40	41+
Others	$18.53	.85 each	.57 each

Per CRS, 25-1-801 the following fees may be charged for copies of medical records. Records will be provided to other health care providers at no charge. **PLEASE ALLOW 10 BUSINESS DAYS FOR PROCESSING.**

Section E

_____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.

My treatment, payment, enrollment or eligibility for benefits may not be conditioned by signing this authorization.

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 disclosure by the recipient and is no longer protected by the HIPAA privacy rule.

Without my express revocation, unless otherwise indicated above this consent will automatically expire 180 days from the date signed below.

_____

Patient or Authorized Representative Signature Date Relationship