HIPAA Authorization to Use or Disclose Protected Health Information

The following information is REQUIRED:

1.

Patient Name | **Date of Birth** | **Date/s of Treatment, Year of Treatment, or All Dates**

2. **I hereby freely and voluntarily authorize Cedar Springs Hospital to:**

☐ **Release my protected health information to:** ______________________________

Name of Individual/**SELF**, Facility, Organization**-** Required for **ALL** Requests

RELATIONSHIP TO PATIENT:

☐ SELF ☐ PARENT/Guardian

☐ SPOUSE

☐ OTHER ____________________

____
Address-Required for **ALL** Requests **(*If* for yourself complete your address)**

____
Phone-Required for **ALL** Requests

3. **OR** ☐ **Obtain my protected health information from:**

____
Name of Individual, Facility or Organization

____
Address

____
City, State, Zip Code

____
Phone Number Fax Number

4. **The purpose of this disclosure:**

☐The patient/personal ☐Insurance purposes ☐Educational placement ☐Legal reasons ☐Medical treatment ☐Discharge planning

☐Continued treatment ☐Other (explain)____________________________ ☐**Verbal exchange of information**

5. **Information to be used or disclosed:**

Best Practice: Request the Discharge Summary & Psychiatric Evaluation for an overview of your treatment, diagnosis, & discharge plan.

☐**Discharge Summary** ☐**Psychiatric Evaluation** ☐History & Physical ☐Aftercare Plan/Packet ☐ Discharge Medications

☐Treatment Plan(s) ☐Lab/X-Ray results ☐Progress Report (for verbal exchange marked above) ☐Other (explain)______________________

I understand that my medical records may contain information regarding mental health, psychotherapy notes, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law*. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Cedar Springs Behavioral health System Privacy officer, except to the extent that action has already been taken in reliance on it.

- Check when you want this authorization to expire: _______6 months following the date of this signature, or_______ other date or condition specified: ____________**, or if neither is checked this authorization will expire one year from the date of signature.**

6. **Signatures:**

______________________________ ______________
Signature of Patient/– when applicable by law or hospital policy Date- Required

______________________________ ______________ ______________
Signature of Guardian or Representative Date- Required Relationship to Patient

______________________________ ______________
Signature of Witness/ Signature of unit staff for continued care see- below Date-Required

☐ **Only staff signature required; this information is being requested under HIPAA for continued care of the patient** (Dept/medrec/Signature single page 2018/

(CSH-106)

Cedar Springs Hospital
2135 Southgate Road, Colorado Springs, CO. 80906
719-633-4114 Fax: 719-633-6404
NOTICE AND ACKNOWLEDGEMENT OF FEE FOR COPIES

Notice to patients or their representatives requesting medical record copies. Below is information regarding federal and state regulations for cost of copies for records requested by individuals, legal guardians, third parties or other healthcare providers. Please sign below acknowledging you accept these and understand you will be charge for copies of requested records in compliance with this fee schedule.

Unless otherwise prohibited by law, a representative of the patient, other than a personal representative as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) 164.502(g), with the patient's written authorization, shall pay for the reasonable cost of obtaining a copy of the patient's record. The discharged patient or personal representative (as defined under HIPAA 164.502(g) shall pay for the reasonable cost of obtaining a copy of his/her patient record.

For requestors other than the patient or personal representative (guardian), there may be additional cost as allowed by the OCR regulations.

"Under HIPAA, a hospital / healthcare provider may charge a patient or a personal representative a reasonable, cost-based fee for providing a copy of medical records; this fee may encompass the cost of copying (including the cost of supplies for and labor of copying) and postage. However, health care facilities may charge third parties fees that are established under state law. Thus, the HIPAA fee limitations do not apply when records are released under other HIPAA-compliant situations, such as requests that are based on an individual's authorization."

No fees shall be charged by a health care provider of patient records for requests for medical records received from another health care provider or to an actual healthcare provider solely for the purpose of providing continuing medical care to a patient.

For one or more specific classes of records or services, institutions may charge additional sums upon presenting a justification therefore acceptable to the Department.

A copy service company contracted by Cedar Springs Hospital will be preparing the copies and billing the appropriate responsible person.

____ ____________

Patient's signature or patient's legal representative Date