CEDAR SPRINGS HOSPITAL
Creating hope. Saving lives. Healing families.

Patient Sticker

Authorization to Release Protected Health Information

Patient Name:_____ **Date of Birth:**_____**Phone #:**_____
(Please print)

I authorize release (Please Circle One) **To / From:**	(Please Circle One) **To / From:**
Cedar Springs Hospital 2135 Southgate Road Colorado Springs, CO 80906 Phone: 719-633-6114 Fax: 719-633-6404	_____ Name of Person or Entity _____ Address _____ City and State Phone # Fax #

My *initials* below signify that I consent for the following type(s) of information to be released to the above individual/entity.
_____ Substance Use Disorder Information _____Psychiatric conditions _____ HIV or AIDs related information _____Medical conditions

Do **not** release the following:_____

Treatment Dates: _____

Information that may be released:

☐**Discharge Summary**	☐**Physician's Psychiatric Evaluation**	☐**Physician's Progress Notes**
☐**History and Physical Exam Report**	☐**Lab Results**	☐**Medication Record**
☐**Discharge Plan/Continuing Care Plan**	☐**Psychosocial Assessment**	☐**Intake Assessment**
☐**Substance Abuse/Use Documentation**	☐**Other (specify)**_____	☐**Entire Record**
☐**Verbal Exchange**		

PURPOSE FOR WHICH INFORMATION IS TO BE USED:

___ Continuing Care/Treatment/Care Coordination	___ School	___ Disability Determination/Benefits	___ Payment/Billing
	___ Personal	___ Employment conditions	___Healthcare Operations
___ Legal ___ Other			

If for legal purposes, give specific reason: (must be completed)_____

AUTHORIZATION:
I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure. Refer to the Notice for Privacy Practices regarding authorized disclosures. A legible copy of the Authorization or my signature thereon may be used with the same effectiveness as an original. Any information protected by Federal Regulations governing confidentiality of substance use disorder patient records (42 CFR Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure. Facility is not liable for such re-disclosures.

This consent expires 180 days from the date below unless otherwise specified: (cannot exceed 180 days) _____

_____
Signature of Patient (15 years and older) **Date** **Signature of Parent/Guardian, if applicable** **Date**

_____
Witness, if applicable **Date**

Revocation: I hereby revoke the above authorization: Signature_____***Date***_____