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

Patient Label

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

By completing this form, I am authorizing the exchange of my Protected Health Information (PHI) between:

CEDAR SPRINGS HOSPITAL 2135 Southgate Road Colorado Springs, CO 80906 Phone: 719-633-4114 Fax: 719-633-6404 Email: Cedarsprings medicalrecords@uhsinc.com	&	_____ Name of Person or Entity **Relationship to Patient** _____ Address _____ City and State _____ Phone Fax Email Please send records via: ☐ MAIL ☐ FAX ☐ EMAIL (Check One)

Initialing below signifies my consent to disclose each of the following type(s) of information:

_____ Substance Use Disorder(s) _____Psychiatric Conditions _____ HIV and/or AIDs _____Medical Conditions

Treatment Dates Requested: _____

Do **not** release:_____

Please release the following:

- ☐ **Physician's Psychiatric Evaluation**
- ☐ **History and Physical Examination**
- ☐ **Discharge Plan/Continuing Care Plan**
- ☐ **Substance Abuse/Use Documentation**
- ☐ **Other**_____
- ☐ **Physician's Progress Notes**
- ☐ **Lab Results**
- ☐ **Psychosocial Assessment**
- ☐ **Verbal Exchange**
- ☐ **Physician's Discharge Summary**
- ☐ **Medication Record**
- ☐ **Intake Assessment**
- ☐ **Entire Record**
- ☐ **Dates of Treatment**

REASON(S) FOR OBTAINING INFORMATION:

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

If for legal purposes, please specify reason: (REQUIRED) _____

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 when 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. The facility is not liable for such re-disclosures.

This consent expires 180 days after signing unless otherwise specified. If applicable, provide alternate expiration date _____ _____
(Must be less than 180 days)

_____

Signature of Patient (Minors 15 and older must sign for self) Date Signature of Parent/Guardian, if applicable Date

_____

Witness, if applicable Date

REVOCATION: ***I hereby revoke the above authorization: Signature*** _____ ***Date*** _____