National Jewish Health

Authorization to Release Protected Health Information

Patient Information

Full Name _____ Medical Record # _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Date of Birth _____

I hereby authorize:

- ☐ National Jewish Health - Main Campus 1400 Jackson St Denver, CO 80206 PH (303) 398-1580 FAX (303) 398-1211
- ☐ NJH - Highlands Ranch 8671 S. Quebec St. Ste 120 Highlands Ranch, CO 80130 PH (303) 703-3646 FAX (303) 738-1385
- ☐ NJH - South Denver 499 E. Hampden Ave. Ste 300 Englewood, CO 80113 PH (303) 788-8500 FAX (303) 788-8505
- ☐ Other:

Name/Title Organization _____

Address _____

City/State/Zip _____ Phone _____ Fax _____

Release To

Release to:

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- ☐ Other:

Name/Title Organization _____

Address _____

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Address _____

City/State/Zip _____ Phone _____ Fax _____

Purpose & PHI Disclosed

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

For Treatment Date(s) _____

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

☐ Other _____

Fees

Pages	1-10	11-40	41+
Patient	$14.00	.50 each	.33 each
Others	$16.50	.75 each	.50 each

According to Colorado State Statute, 6 C.C.R. 1011-1, Chapter 2 Part 5.2.3.4 the following fees may be charged for copies of medical records. Records will be provided to other health care providers at no charge.

Authorization

_____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 my 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.

Signature

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 _____