Release of Information Form

Tepeyac Community Health Center • Attn: Health Records Department
4725 High St., Denver, CO 80216 • Ph: 303-458-5302 • Fax: 303-433-7452

Authorization for Tepeyac to Obtain or Disclose my Protected Health Information (*Required)

*Patient Name:		*Date of Birth:	
Previous Name:		*Daytime Phone:	
Date Records Needed By:			

If both boxes checked, Tepeyac staff will release records as specified and send the authorization request to the location listed.

***I request and authorize Tepeyac to:** ☐Release To ☐Obtain From ***via (choose one)** ☐Fax ☐Mail ☐Email

Name:				Phone:	
Address:				Fax:	
City:				Email:	
State:		Zip Code:		Send via unencrypted email if encrypted email is unsuccessful. ☐	

***You may use or disclose the following health information (mark all that apply):**

☐Verbal Only ☐Records Only ☐Verbal and Records ☐Appointment Info Only (Date/Time Only; No Reason/Details)

Types of Information to Release:

☐Billing Records ☐Imaging/Diagnostic Reports ☐Medication List
☐Encounter Notes ☐Immunizations ☐OB Records
☐Dental: ☐Records ☐X-rays ☐Lab and Pathology Reports ☐Other _____

☐All healthcare information in my designated record set (excludes sensitive information requiring specific authorization unless specified below) for the last _____ year(s).

I understand that my health record may include information on a diagnosis/treatment related to psychiatric, psychological, or mental conditions, drug and/or alcohol use, sexually transmitted infections (STIs), AIDS, and/or HIV status, and genetic testing.

I consent for the following information to be disclosed: (mark any/all that apply):

☐Drug and/or alcohol use ☐Psychiatric disorder/mental health ☐HIV/AIDS ☐STIs

***Reason for Authorization:** ☐At individual's request ☐Other: _____

Expiration/Revocation: I understand that I may revoke this authorization at any time by giving written notice to Tepeyac. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my information have already acted in reliance on this authorization. Without such notice, this authorization expires one year from date of signature, unless specified below:

☐Event (one time release) OR ☐Expiration Date: ____/____/_____

The information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by federal law. State and federal law specifically requires that any patient medical record and/or personal health information containing drug and alcohol diagnosis and treatment, mental health, and sexually transmitted infections, including HIV/AIDS are privileged and confidential and may only be disclosed by express authorization, except as required by law. I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 CFR Part 2 and Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may refuse to sign this authorization. Tepeyac may not condition treatment, payment, enrollment, or eligibility on the authorization of this release. Electronic signatures. This Authorization (Agreement) is, and related documents entered into connection with this Agreement are, deemed signed when a party's signature is delivered electronically. The signor is executing this Agreement electronically and intends to be bound by the Agreement and agrees that the electronic signature shall be deemed original signatures having the same legal effect as original signatures to the fullest extent permitted by applicable law, including the Federal Electronic Signatures in Global and National Commerce Act, and any similar state law based on the Uniform Electronic Transactions Act, and the parties hereby waive any objection to the contrary. The signor acknowledges that this term is hereby incorporated into the Agreement.

*Signature of Patient/Legally Responsible Party	Relationship to Patient	*Date

A minor's signature alone is necessary and sufficient to release health information related to confidential services the minor legally consented to under Colorado law. The minor's signature below is required for information pertaining to minor confidential services to be released.

Signature of Minor Patient	Date