# Authorization to Release Protected Health Information

National Jewish Health

**Patient Information**

Full Name ______________________ Medical Record # __________

Addresss ______________________

City ______________ State ______________ Zip __________

Phone # ______________ Date of Birth ______________

**Release From**

**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

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**Purpose & PHI Disclosed**

- Continuation of Care
- Insurance
- Legal
- Personal Use
- Verbal Communications
- 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**

I authorize any or all of the following conditions to be disclosed: Sickle Cell Anemia, genetic testing, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), communicable diseases, venereal diseases, drug abuse, alcoholism, alcohol abuse, and psychological or psychiatric conditions, if any.

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 do not 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 ______________