



Pueblo Department of Public Health and Environment
 101 W. 9th Street
 Pueblo, CO 81003
 Clinic Phone 719-583-4380 • Clinic Fax 719-583-4375

AUTHORIZATION TO RELEASE INFORMATION

Release from:

Patient (please print):

Name: _____
 DOB: _____
 Address: _____
 Phone: _____

Release to:

Clinical Services _____
 Pueblo Department of Public
 Health and Environment _____
 101 W. 9th Street _____
 Pueblo, Colorado 81003 _____

Information to be released from date _____ to _____

I specifically authorize the release of information relating to:

- | | | |
|--|---|--|
| <input type="checkbox"/> History and physical exam | <input type="checkbox"/> Progress notes | <input type="checkbox"/> Immunizations |
| <input type="checkbox"/> Lab reports | <input type="checkbox"/> X-ray reports | <input type="checkbox"/> PPD Results |
| <input type="checkbox"/> HIV related information | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Complete hospital record | | |

Please Note: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, genetic testing, human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted diseases.

Purpose of Disclosure:

- | | |
|--|------------------------------------|
| <input type="checkbox"/> Personal use | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Other (Please specify): _____ | |

I understand this authorization will expire one year after this form has been signed. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken. I understand that information obtained or disclosed may be subject to re-disclosure by the recipient and no longer be protected by federal or state privacy regulations. I understand I may see and copy the information described on this form if I ask for it (permitted by federal or state law to the extent the state law provides greater access) and that I can request a copy of this form after I sign it.

I have been informed that the Pueblo Department of Public Health and Environment will not receive financial or in-kind compensation in exchange for using or disclosing the health information above. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment. There may be a reasonable fee assessed for records I request for my own use. (See clinic receptionist for pricing information).

I understand that I may refuse to sign this authorization. I further understand that a copy or facsimile of this authorization with my signature may be used with the same effectiveness as an original.

 Signature of Patient or Parent/Authorized Person

 Date

Print Name: _____

FOR OFFICE USE ONLY

RECORDS RECEIVED BY: _____ DATE: _____

Date request filled: _____

By: _____