711 Barnes
La Junta, CO 81050
Phone: 719-384-5446
Fax: 719-384-8411

Southeast Health Group

Patient Authorization to Disclose Protected Health Information

Please send a copy of this release with the requested records.

PATIENT INFORMATION (Please Print)

Patient Name		Date of Birth	Social Security Number
Address	City	Zip	Phone

I hereby authorize Southeast Health Group listed below to disclose/release the Protected Health Information specified in this request to the organization, agency ,or patient named.

Release by:	Release to:
______________ Southeast Health Group	______________ Organization, Agency, Individual
______________ Address	______________ Attention:
______________ City, State, Zip Code	______________ Address
______________ Phone/Fax Numbers	______________ Phone/Fax Numbers

Treatment Date(s):______________________

Purpose: ☐ Further Medical Care ☐ Worker's Comp ☐ Personal Use ☐ Insurance ☐ Legal ☐ Marketing/Fundraising ☐ Other:______________________

Type of Disclosure Authorized & Delivery Instructions:

☐ Provide copies of records to organization/agency/individual
☐ Mail Records directly to address above
☐ Call to pick-up records:______________________
☐ Fax records to:______________________

Pertinent Protect Health Information Allowed to be Included:

☐ All Records (Last 2 years)	☐ Radiology	☐ Discharge Summary	☐ Alcohol Abuse	☐ Physical Therapy
☐ History & Physical/Consult	☐ Outpatient Record	☐ Medication Records	☐ Substance Abuse	
☐ Operative Report	☐ Progress Notes	☐ Psych Health Records	☐ Research	
☐ Labs	☐ Physician Orders	☐ Other (specify):______________________		

Authorization: I certify that this request is 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 in writing by submitting my request in writing to Southeast Health Group. I understand that information provided based on this Authorization may be re-disclosed to another party by the authorized recipient and that SHG has no control over the additional disclosure and can't protect the information after it is released based on this Authorization. A copy or fax of this authorization will be as valid as the original. I understand that information may be disclosed to make claims on my behalf for the recipient of aid, insurance, or medical assistance. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. If I have questions about disclosure of my health information, I may contact Southeast Health Group. **Expiration:** Unless I specifically say in writing that I cancel this consent, it will automatically expire in one (1) year from the date of my signature. Date of Expiration: ___________. **Acknowledgement:** I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

SIGNATURE: ______________________________ DATE:______________

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law.
Relationship (if other than patient):______________________ ☐ Power of Attorney ☐ Death Certificate
Name of individual signing on behalf of patient:______________________
Verification: ☐ Drivers License # ______________________ ☐ Other Appropriate ID: ____________

A flat fee of $20.00 may be charged for non-coordination of care record requests.

Revised 11/7/2017