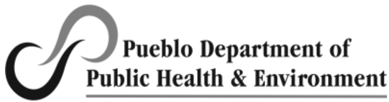

Pueblo Department of Public Health and Environment
101 W. 9th Street
Pueblo, CO 81003
Clinic Phone 719-583-4380 • Clinic Fax 719-583-4375

# AUTHORIZATION TO RELEASE INFORMATION

| **Release from:** | **Patient (please print):** | **Release to:** |
|---|---|---|
| Clinical Services | Name: ______________________________ | ______________________________ |
| Pueblo Department of Public | DOB: ______________________________ | ______________________________ |
| Health and Environment | Address: ______________________________ | ______________________________ |
| 101 W. 9th Street | Phone: ______________________________ | ______________________________ |
| Pueblo, Colorado 81003 | | |

**Information to be released from date ________________________to________________________**

**I specifically authorize the release of information relating to:**

- ☐ History and physical exam
- ☐ Lab reports
- ☐ HIV related information
- ☐ Complete hospital record
- ☐ Progress notes
- ☐ X-ray reports
- ☐ Other: ____________________
  ____________________
- ☐ Immunizations
- ☐ PPD Results

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

**Purpose of Disclosure:**

- ☐ Personal use
- ☐ Continuing Care
- ☐ Insurance
- ☐ Legal
- ☐ 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 RELEASED TO:** ______________________________________________ **DATE:** ______________________

☐ Mailed ☐ Faxed ☐ Picked up in person ☐ Other ______________

Date request filled: ____________________________________ By: ____________________________________