 [ ]  **Authorization to Communicate**

 [ ]  **Release of Information**

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| **MRN:** | **ID checked by:** |
| 1. **Patient Information**
 |
| Name (First MI Last): | DOB: | SSN \*\*\*-\*\*-\_\_\_\_\_\_\_ |
| Address: | Phone: |
| City: | State: | ZIP: |
| Maiden/Prior Name: | Email:C# |

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| 1. **MRH location(s) where patient received care**
 |
| [ ]  **Memorial Regional Health** 750 Hospital Loop, Craig CO 81625 For Medical Records:**Phone: 970-826-3140 / Fax: 970-826-3149** | [ ]  **MRH Medical Clinic** 750 Hospital Loop, Craig CO 81625 | [ ]  **MRH Specialty Clinic**600 Russell Street, Craig CO 81625 |

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| **C1. MRH is Authorized to Disclose Information TO:**  | * **ALL agencies listed below, as needed.**
* **ONLY the agencies as indicated below.**
 |
| [ ] Children’s Hospital Colorado | [ ] Community Budget Center | [ ] Dept of Human Services | [ ] Horizons |
| [ ] Integrated Community | [ ] Love Inc. | [ ] Mind Springs Health | [ ] Open Heart Advocates |
| [ ] Northwest Colorado Health | [ ] Northwest Colorado Options for Long-term Care | [ ] Northwest Colorado Center for Independence  | [ ] Oxford House |
| [ ] Senior Social Center | [ ] The Health Partnership | [ ] Rocky Mtn Health Plans | [ ] UCHealth |
| [ ] Memorial Regional Health | [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **C2. Information MRH is Authorized to Disclose**  | * **ALL information listed below, as needed.**
* **ONLY information as indicated below.**
 |
| [ ] History & physical | [ ] Emergency Dept visit notes | [ ] Discharge Summary notes |
| [ ] Clinic / Appointment notes | [ ] Lab / diagnostic test results | [ ] Radiology results / films |
| [ ] Operative/Procedure reports | [ ] Pathology reports | [ ] Therapy notes (PT/OT) |
| [ ] Social needs screening | [ ] Billing | [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **D1. MRH is Authorized to Receive Information FROM::**  | * **ALL agencies listed below, as needed.**
* **ONLY the agencies as indicated below.**
 |
| [ ] Children’s Hospital Colorado | [ ] Community Budget Center | [ ] Dept of Human Services | [ ] Horizons |
| [ ] Integrated Community | [ ] Love Inc. | [ ] Mind Springs Health | [ ] Open Heart Advocates |
| [ ] Northwest Colorado Health | [ ] Northwest Colorado Options for Long-term Care | [ ] Northwest Colorado Center for Independence  | [ ] Oxford House |
| [ ] Senior Social Center | [ ] The Health Partnership | [ ] Rocky Mtn Health Plans | [ ] UCHealth |
| [ ] Memorial Regional Health | [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **D2. Information MRH is Authorized to Receive**  | * **ALL information listed below, as needed.**
* **ONLY information as indicated below.**
 |
| [ ] History & physical | [ ] Emergency Dept visit notes | [ ] Discharge Summary notes |
| [ ] Clinic / Appointment notes | [ ] Lab / diagnostic test results | [ ] Radiology results / films |
| [ ] Operative/Procedure reports | [ ] Pathology reports | [ ] Therapy notes (PT/OT) |
| [ ] Social needs screening | [ ] Billing | [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **E. Purpose of this Release of Information** |
| [ ] Personal / At my request | [ ] Disability | [ ] Insurance | [ ] Legal |
| [ ] Consultation / Continuity of Care | [ ] Transfer of Care to another Provider | [ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **F. How information may be communicated** |
| [ ] Email | [ ] In-person | [ ] Fax | [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **G. Date range of information to be disclosed / received** |
|   **FROM:** Month\_\_\_\_\_\_\_\_ / Day \_\_\_\_\_\_\_\_\_\_/ Year\_\_\_\_\_\_\_\_\_\_ |   **TO:** Month\_\_\_\_\_\_\_\_\_\_ / Day \_\_\_\_\_\_\_\_\_\_/ Year\_\_\_\_\_\_\_\_\_\_ |

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| 1. **DISCLOSURES**
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| **REVOCATION** | I understand I may revoke this authorization at any time by providing written notice to the agency noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy. |
| **EXPIRATION**  | **This authorization will expire in 90-days from the date of consent** **OR on (specify date):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **AUTHORIZATION** | * I hereby authorize the above agencies to disclose health and social needs information concerning the above named patient to the parties identified in the section entitled “C1. Authorized to Disclose Information TO” and “D1. Authorized to Receive Information FROM.”
* I understand the information to be received and/or released may include information regarding treatment of mental health, alcohol and drug use, and HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome) related information.
* I understand once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected.
* I further understand that I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, or payment or eligibility of my benefits.
* **A photocopy/fax of this authorization will be treated in the same manner as an original.**
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| **CONSENT** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature OR Date of ConsentSignature of Person Authorizing Consent if acting on behalf of a minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient, if signing on behalf of the patient**I understand I am not required to sign this Release of Information if I do not wish to release my records. I understand my ability to receive services may be limited if a Release of Information is not signed, allowing agencies to communicate on my behalf, or on behalf of the patient if the patient is a minor.** |

**COMMENTS (specify section to which comments apply):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Initials \_\_\_\_\_\_\_\_\_\_\_\_

 12/2023