Pueblo Department of Public Health & Environment

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

AUTHORIZATION TO RELEASE INFORMATION

Release from:

_____
_____
_____
_____

Patient (please print):

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

Release to:

Clinical Services
Pueblo Department of
Public Health & Environment
101 W. 9th Street
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

Purpose of Disclosure:

- ☐ Changing physicians
- ☐ Consultation/second opinion
- ☐ Continuing Care
- ☐ School
- ☐ Insurance
- ☐ Legal
- ☐ SSI request
- ☐ Workers' Compensation
- ☐ 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. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form. 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.

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:** _____

RELATIONSHIP TO PATIENT: _____

Date request filled: _____ By: _____