CBSI
COLORADO BRAIN & SPINE INSTITUTE

Authorization to Disclose Protected Health Information

Patient name _____ Formerly known as _____ Birth date _____

Address _____ City/State _____ Zip _____ Phone _____

Purpose of Request: ☐ Continuation of care ☐ Personal ☐ Legal ☐ Insurance ☐ Other _____

I authorize release to _____ Phone _____

Name/Facility _____ Fax _____

Address _____ City/State _____ Zip _____

Date of service range (month/year): From _____ to _____

If released to self, select method of release: ☐ EMAIL _____

☐ MAIL: Name_____ Address:_____ City/State/ZIP:_____

☐ FAX records to: #_____ Attn:_____

☐ PICK UP: Please provide a phone # we can call when they are ready: _____

☐ Facesheet
☐ Billing
☐ Clinical information generated by our office

***I hereby consent to disclose the above bolded specialized information.** _____
Patient's signature is required.

1. I authorize the release of my medical record, including photographs.
2. This authorization is voluntary and the disclosure is made at my request.
3. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
4. Multiple requests are authorized if the purpose of the request remains the same.
5. I have a right to revoke this authorization at any time, and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
6. I need not sign this form to ensure health care treatment.

I request this authorization to expire on _____ or 180 days from the date signed below and **covers only treatment for the date(s) specified above**.

I am also aware fees (outlined below) for copy services may apply. NOTE: Fees/charges will comply with all Laws and regulation applicable to the release of information. Standard copying fees are as follows:

To patient: Paper delivery: 1-10 are free, 11-99 pages are $6.50, 100 or more pages delivered electronically only. Free through Athena portal.

To third party recipient: $18.53 (retrieval fee for pages 1-10) **plus** $0.85 (each pages 11–40) **plus** $0.57 (each page over 40)

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity to which this message is addressed. These documents may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**.

_____ _____
Signature of patient or legal representative Date

FOR OFFICIAL USE ONLY

Released completed on-site ☐ Processed by (Name) _____ Date _____

Patient's ID type and number: ☐ Driver's license_____ ☐ State ID_____ ☐ Military ID _____

If signed by a legal representative, include a copy of the document: ☐ Death certificate ☐ Power of attorney ☐ Living Will

Request forwarded to HIM ☐ Forwarded by (Name) _____ Date _____

Once this form is completed and signed, please email to cbsi@cbsi.md or fax to 303-783-2002.