CEDAR POINT HEALTH
Cedarpointhealth.com 300 S. Nevada Ave. Montrose, Co 81401 Phone (970) 249-7751 Fax (970) 249-5029

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete this form to authorize Cedar Point Health (CPH) to request your personal health information on your behalf. You may revoke this authorization in writing or by contacting medical records at CPH. Once health information is disclosed, the organization that receives it may re-disclose it. Privacy laws may no longer protect it

PATIENT INFORMATION:	Patient Name: _____ Date of Birth: _____ Phone Number: _____
AUTHORIZATION TO:	☐ Send Information ☐ Request Information
INFORMATION MAY BE RELEASED **FROM**:	Organization: _____ Address: _____ Phone Number:_____Fax Number: _____
INFORMATION MAY BE RELEASED **TO**:	Organization: _____ Address: _____ Phone Number:_____Fax Number: _____
INFORMATION TO BE RELEASED:	☐ All health information ☐ Radiology ☐ Office Notes ☐ Labs ☐ Pathology Reports ☐ Mental health ☐ Immunization Records ☐ Mental health substance use/abuse information _____ initial ☐ Other: _____
	Optional ☐ Health information between the following dates: _____ to _____ ☐ Exclude:
AUTHORIZATION ENDS:	☐ On (date): _____ ☐ When the following occurs: _____ *If no date provided, authorization ends one year from signing.
PURPOSE:	Transfer to New Provider and/or Continuity of Care

PATIENT NAME (PRINT) _____ SIGNATURE _____ DATE _____

PERSON SIGNING ON BEHALF OF PATIENT _____ RELATIONSHIP TO PATIENT _____