AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Please complete this form **to authorize Cedar Point Health (CPH) to SEND 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
INFORMATION MAY BE RELEASED **FROM**:	Organization: **Cedar Point Health** _____ Address: 2303 S. Townsend Ave., Suite A; Montrose, CO 81401 Phone Number: 970-249-7751 Fax Number: **970-249-5029**
INFORMATION MAY BE RELEASED **TO**:	Organization: _____ Address: _____ Phone Number: _____ Fax Number: _____
INFORMATION TO BE RELEASED:	☐ All health information ☐ Radiology ☐ Office Notes ☐ Labs ☐ Pathology Reports ☐ Other: _____ ☐ Immunization Records
	Optional ☐ Health information between the following dates: _____ to _____ ☐ Include psychotherapy notes. To authorize, initial here _____ ☐ Exclude:
AUTHORIZATION ENDS:	☐ On (date): _____ ☐ When the following occurs: _____ *If no date provided, authorization ends one year from signing.
PURPOSE:	☐ Transfer to New Provider ☐ Consult/Referral ☐ Other: _____

_____ _____ _____

PATIENT NAME (PRINT) SIGNATURE DATE

_____ _____

PERSON SIGNING ON BEHALF OF PATIENT RELATIONSHIP TO PATIENT