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
INFORMATION MAY BE RELEASED **FROM**:	Organization: ___________________________ Address: ___________________________ Phone Number: ___________________________ Fax Number: ___________________________
INFORMATION MAY BE RELEASED **TO**:	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 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