

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: <u>Cedar Point Health</u> Address: <u>2303 S. Townsend Ave., Suite A; Montrose, CO 81401</u> Phone Number: <u>970-249-7751</u> Fax Number: _____	
INFORMATION TO BE RELEASED:	☐ All health information ☐ Office Notes ☐ Pathology Reports ☐ Immunization Records ☐ Radiology ☐ Labs ☐ Other: _____ 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