

PATIENT ACCESS REQUEST FOR PROTECTED HEALTH INFORMATION

NOTE: This form is only for a patient or legal representative to request that medical records be sent to the patient. A HIPAA compliant Authorization to Release Medical Information must be submitted to release the patient's information to anyone other than the patient or legal representative.

1. Patient Information (Please print)

Patient's Full Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Date of Incident/Service: _____

2. What records do you want? _____

3. Delivery Method for Copies of Records:

- I wish to inspect the records at the District's administrative offices at 702 Cedar Street, Hudson, Colorado, and do not want any copies of the records delivered to me.
- By pick-up at District's administrative offices at 702 Cedar Street, Hudson, Colorado. *Records not picked-up within 30 days will be destroyed, without refund of any fees paid.*
- By mail to the following address: _____
- By unsecured fax to the following fax number: _____
- By unsecured email to the following email address: _____

4. _____
Printed Name of Legal Representative if Patient is Not Capable of Signing

If this form is not signed by patient, identify relationship to patient.

5. _____
Relationship to Patient if signed by Legal Respective. (example: Guardian of a Minor, Deceased's Next of Kin)

6. _____
Signature of Patient or Legal Representative **Date**

7. Personal Identification Required.

The person submitting this form must verify their identity. If Legal Representative or other, provide documentation establishing authority such as Power of Attorney. Mark the form of government issued Photo Identification being submitted with this form: [] Driver's License [] Passport [] Identification Card issued by Colorado Dept. of Revenue [] Other: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO THIRD-PARTY

Patient Information:

Patient Name: _____ Date of Birth: _____
Address: _____
Telephone: _____ Email Address: _____

I, _____, ^{Patient or Patient's Representative} authorize Hudson Fire Protection District ("District") to release the following records, including any Protected Health Information regarding the patient that the records contain, to the below individual (and organization if applicable). Please list the records you are authorizing for release with as much detail as possible, including the type of record, a date or date range, the specific subject matter, and the names of persons and locations. Please attach additional pages if more space is needed. **You must specifically authorize the release of records relating to drug/alcohol abuse, child abuse, HIV status, genetic testing, sickle cell anemia, or mental health records.** A separate authorization is required for release of psychotherapy notes.

Records Requested: _____

The records listed above may be released to the following individual(s) or organization(s):

Name of Recipient: _____ Organization: _____
Address: _____
For: _____

Delivery Method for Copies of Records:

- I wish to inspect the records at the District's administrative offices at 702 Cedar Street, Hudson, Colorado, and do not want any copies of the records delivered to me.
 - By pick-up at the District's administrative offices at 702 Cedar Street, Hudson, Colorado. *Records not picked-up within 30 days will be destroyed, without refund of any fees paid.*
 - By mail to the following address: _____
 - By unsecured fax to the following fax number: _____
 - By unsecured email to the following email address: _____
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Expiration. Unless earlier revoked, this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law.

Revocation. I have the right to revoke this authorization in writing at any time, except to the extent that action has been taken based on this authorization.

Patient Rights. I understand I have a right to a copy of this authorization. I have the right to inspect or copy the information to be disclosed as provided in 45 CFR 164.524. I have the right to inspect or amend my medical records as provided in 45 CFR 164.526. I have the right to an accounting of the use and disclosure of my health information to any third party as provided in 45 CFR 164.528.

Re-disclosure. I understand that any disclosure of Protected Health Information carries with it the potential for unauthorized re-disclosure and may no longer be protected by federal confidentiality rules.

SIGNATURE: I understand that authorization for the disclosure of these records and Protected Health Information is voluntary and I can refuse to sign this authorization. I understand that medical treatment, payment, enrollment, and eligibility for benefits cannot be, and are not, conditioned on whether I sign this authorization. Photocopies of this authorization may be used in lieu of the original.

Signature of Patient or Personal Representative: _____ Date: _____

Printed Name of Patient or Personal Representative: _____ Date: _____

Description of Personal Representative's Authority: _____

If Legal Representative or other, provide documentation establishing authority such as Power of Attorney.

Personal Identification Required: The person submitting this form must verify their identity. Mark the form of government issued Photo Identification being submitted with this form: [] Driver's License [] Passport [] Identification Card issued by Colorado Dept. of Revenue [] Other: _____