AWH Authorization to Release Protected Health Information

Patient Legal Name Date of Birth SSN

Address Phone #

City State Zip Code

I hereby authorize the following facility to disclose Protected Health Information of the patient listed above.

FROM:	**TO: (MUST BE COMPLETE ADDRESS)**
Associates in Women's Health	Name/Facility:__________________________________
2801 Youngfield St. #200	Address:_____________________________________
Golden, CO 80401	____
Phone: 303-940-1867	Phone #:_____________________________________
Fax: 303-940-1894	Fax #: ______________________________________

Reason to Release Protected Health Information:

____

Type of Information Requested:

○ Entire Record ○ Labs ○ Operative Report ○ Ultrasound ○ Office Visit Notes

○ Info pertaining only to: ____

○ Other:____

Expiration: This authorization shall expire upon: ○ Fulfillment of this request ○ Date: _______________

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. The facility will not condition treatment, payment, enrollment, or eligibility for benefits upon authorization unless specified use applies to specific exceptions. I understand that there may be a fee involved with the fulfillment of this request. SEE FEE SCHEDULE BELOW. I understand that the term Complete Chart for release of Protected Health Information means that **only records generated by this facility will be released.** I have read the above and authorize the disclosure of the protected health information. For closed clinics, there will always be a fee for copying of records.

_______________________________________ _______________________________

Signature **Date**

Fee Schedule

Fees for duplication of Protected Health Information shall follow the Regulations for Patient Medical Reproduction Fees 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4. which states the patient shall pay for the reasonable cost of obtaining a copy of his/her patient record, not to exceed $14.00 for the first 10 or fewer pages, $0.50 per page for pages 11-40, and $0.33 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any, may be charged.

To ensure timely processing of medical records, please fill authorization out completely.