WOMEN'S HEALTH
BOULDER VALLEY WOMEN'S HEALTH CENTER

Authorization to Release Protected Health Information

Place label or

1. PRINT Name _____ **DOB** _____/_____/_____

I hereby authorize the release / disclosure of the following specified information:

- □ **ONLY** the following: all Pap results including high-risk HPV and Colposcopy / LEEP records ***(Provider _____)***
- □ Most recent annual exam / postpartum exam including chart notes, lab work, and Pap results ***(Provider _____)***
- □ All health information *generated* by facility (do not send health information from other sources) ***(Provider _____)***
- □ All health information *kept* at facility (do include health information from other sources) ***(Provider _____)***
- □ Other, specify _____ ***(Provider _____)***

2. *Unless I have initialed below,* I authorize the release of information regarding the following conditions:

_____Drug abuse _____Psychiatric _____Alcohol abuse _____HIV/AIDS

3. Purpose of release:

☐ Continuing medical care ☐ Personal use ☐ Insurance ☐ Legal ☐ Other _____

4. Check one: ☐ TO / ☐ FROM: **Boulder Valley Women's Health Center**
2855 Valmont Road
Boulder, CO 80301
Phone 303-442-5160 Fax 303-440-8769

5. Check one: ☐ TO / ☐ FROM: Facility/Provider/Individual _____

Address _____

City/State/Zip _____

Phone _____ Fax _____

6. ☐ By checking this box, I authorize sending this release and my health information via fax.

7. Check each box to indicate understanding.

- □ A copy of this authorization shall be utilized with the same effectiveness as the original.
- □ I understand that I may revoke this authorization at any time as stated in Notice of Health Info Practices.
- □ I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on the authorization.
- □ I understand that this authorization will expire *one year from the date of this document,* or:_____(Date of Expiration).
- □ I understand that charges may be incurred for copying costs. The rate set by the State of Colorado is $14.00 for the first 10 or fewer pages, 50 cents per page for pages 11-40, and then 33 cents per page after 40 pages.
- □ I understand that Women's Health may not condition treatment or payment on whether I sign this form.
- □ I understand that information that I have authorized be disclosed may be re-disclosed by the recipient and no longer will be protected by this authorization.

8. _____ _____/_____/_____
Patient Signature **Today's Date**

Sent by _____ Date sent _____/_____/_____ RT PHI