CSU HEALTH NETWORK
COLORADO STATE UNIVERSITY

CSU Health Network
Medical Records
8031 Campus Delivery
Fort Collins, CO 80523

Phone ● 970-491-7509 ● 970-491-2349 ● 970-491-4124 Fax ● 970-491-0226

AUTHORIZATION TO ACCESS OR RELEASE PROTECTED HEALTH INFORMATION

Please Note: The release of all Personal Health Information (PHI) requested from the CSU Health Network Mental Health Services Department will be subject to approval prior to their release. Providers reserve the right to determine if a summary will be released in lieu of the records.

_____

Last Name (Please Print) First Middle AKA

_____

Date of Birth CSU ID # Phone Number

☐ I request that CSU Health Network release my records to the following person or facility:
☐ I request that the facility below release my records to CSU Health Network:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Recipient Email: _____

Purpose of request: ☐ Attorney ☐ Personal Records ☐ Insurance ☐ Continuity of Care ☐ Other_____

MEDICAL RECORDS REQUESTS (CHECK ALL BOXES THAT APPLY):

☐ Medical Records ☐ Psychiatry Records ☐ Counseling Records
☐ Learning Disability/ADHD Eval ☐ Substance Use Records ☐ Lab Only
☐ Genetic Testing ☐ Billing ☐ Other_____

☐ **Limited release:** Records regarding specific illness/injury/mental health (specify records to be released such as; condition and/or approximate dates of service):

_____
_____

DENTAL RECORDS REQUESTS ONLY (check one):

☐ Entire Record ☐ Images Only (Please Specify) _____

For questions regarding Dental Records please call 970-491-4124

Please Note:

- **A $6.00 fee will apply for printing large records, or for burning records to a CD for personal use.**
- **Records can only be released to one recipient per form.**
- **Please allow 15 business days for the release of records from our facility to be processed.**

In accordance with the Colorado State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that:

1. **Information to be released may include information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, mental health or psychiatric treatment, drug and alcohol education and treatment records and/or genetic testing records. I give my specific authorization to release all health care information relating to such diagnosis, testing or treatment.**
2. If I have authorized the release of substance use disorder information that the confidentiality of this information is protected by federal law **(HIPAA and 42 CFR part 2)**. This information cannot be disclosed or re-disclosed without my written consent, unless otherwise specifically provided for in the regulations.
3. Authorizing the use or disclosure of the information identified about is voluntary. I need not sign this form to ensure health care treatment. CSU Health Network personnel will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except; 1) if my treatment is related to research, or, 2) health care services are provided to be solely for the purpose of creating PHI for disclosure to a third party.
4. I may cancel this authorization in writing at any time, except to the extent that action has already been taken to comply or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Without my express cancellation, this authorization will automatically expire upon satisfaction of the need for disclosure, not to exceed 180 days from date of signature. **I understand this authorization will not apply to care provided after the date of my signature.**
5. The Board of Governors of Colorado State University System, Colorado State University and CSU Health Network will not be responsible for recipient's disclosure of information released pursuant to this authorization.
6. There is potential for information that is disclosed pursuant to this authorization to be re-disclosed by the recipient and is therefore no longer protected by Federal or State Law. If another party receives the information as the result of an error in processing my request, I waive any, and all claims related to the error and release the CSU Health Network (and its affiliated entities or governing board) of any liability related to such error.
7. A copy or facsimile may be utilized with the same effectiveness as an original.
8. I will be given a copy of this completed form at my request.

I have read and acknowledge that I understand the terms and conditions of this request. I release both facilities from any liability complying with this request.

_____ _____

Signature of Patient/Client (or Personal Representative) Date

_____

Description of Personal Representative's Authority

To Recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State laws or regulations, which may prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such laws or regulations. A general authorization for release of medical or other information is NOT sufficient for this purpose.