



CONSENT/AUTHORIZATION TO ACCESS OR RELEASE PROTECTED HEALTH INFORMATION

 Last Name (Please Print) First Middle AKA

 Date of Birth CSU ID # Phone Number

PLEASE NOTE: For PHI requested from CSU Health Network, the Mental Health and/or Counseling Records may be summarized and Medical Records will be copied.

- 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: _____

CHECK ALL BOXES THAT APPLY

- Limited to records regarding specific illness/injury/mental health (state condition and approximate dates) _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Psychiatry Records | <input type="checkbox"/> Substance Use Records |
| <input type="checkbox"/> Genetic Testing | <input type="checkbox"/> Counseling Records | <input type="checkbox"/> Learning Disability/ADHD |
| <input type="checkbox"/> Billing | <input type="checkbox"/> Lab only | Evaluation |
| <input type="checkbox"/> Other: | | |

PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSES:

- Attorney Personal Records Insurance Continuity of Care/Another Care Provider
- Other: _____

I understand there is a \$6.00 charge for records copied/summarized for personal purposes. This excludes continuity of care record requests for all medical facilities. Records requested by attorney or insurance purposes are charged based on Colorado State Statutes, the charge for copying is \$18.53 for the first 10 pages; \$0.85 per page for pages 11-40; and \$0.57 for each additional page.

1. I understand that the 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. I understand that 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. I understand 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 understand that 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 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. I understand the potential for information that is disclosed pursuant to this authorization to be re-disclosed by the recipient and 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.

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 may be 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.

A copy of this completed authorization has been given, or offered. _____