memorial regional health

☐ **Authorization to Communicate**
☐ **Release of Information**

MRN: ____________________ **ID checked by:** ____

A. Patient Information

Name (First, MI, Last):	DOB:	SSN***-**- ________
Address:	Phone:	
City:	State:	ZIP:
Maiden/Prior Name:	Email:	

B. MRH Location(s) Where Patient Received Care

☐ **Memorial Regional Health** 750 Hospital Loop, Craig For Medical Records: Phone: 970-826-3140 / Fax: 970-826-3149	☐ **MRH Medical Clinic** 750 Hospital Loop, Craig	☐ **MRH Specialty Clinic** 600 Russell St, Craig

C1. MRH is Authorized to Disclose Information TO:

☐ **ALL agencies listed below, as needed.**
☐ **ONLY the agencies as indicated below.**

- ☐ Children's Hospital Colorado
- ☐ Integrated Community
- ☐ Northwest Colorado Health
- ☐ Senior Social Center
- ☐ Memorial Regional Health
- ☐ Community Budget Center
- ☐ Love, Inc.
- ☐ Northwest Colorado Options for Long-Term Care
- ☐ The Health Partnership
- ☐ Dept of Human Services
- ☐ Mind Springs Health
- ☐ Northwest Colorado Center for Independence
- ☐ Rocky Mtn Health Plans
- ☐ Horizons
- ☐ ACTSS
- ☐ Oxford House
- ☐ UCHealth
- ☐ Other: ____

C2. Information MRH is Authorized to Disclose

☐ **ALL information listed below, as needed.**
☐ **ONLY information as indicated below.**

- ☐ History & physical
- ☐ Clinic/Appointment notes
- ☐ Operative/Procedure reports
- ☐ Social needs screening
- ☐ Emergency Dept visit notes
- ☐ Lab/diagnostic test results
- ☐ Pathology reports
- ☐ Billing
- ☐ Discharge Summary notes
- ☐ Radiology results/films
- ☐ Therapy notes (PT/OT)
- ☐ Other: ______________________

D1. MRH is Authorized to Receive Information FROM:

☐ **ALL agencies listed below, as needed.**
☐ **ONLY the agencies as indicated below.**

- ☐ Children's Hospital Colorado
- ☐ Integrated Community
- ☐ Northwest Colorado Health
- ☐ Senior Social Center
- ☐ Memorial Regional Health
- ☐ Community Budget Center
- ☐ Love, Inc.
- ☐ Northwest Colorado Options for Long-Term Care
- ☐ The Health Partnership
- ☐ Dept of Human Services
- ☐ Mind Springs Health
- ☐ Northwest Colorado Center for Independence
- ☐ Rocky Mtn Health Plans
- ☐ Horizons
- ☐ ACTSS
- ☐ Oxford House
- ☐ UCHealth
- ☐ Other: ____

D2. Information MRH is Authorized to Receive

☐ **ALL information listed below, as needed.**
☐ **ONLY information as indicated below.**

- ☐ History & physical
- ☐ Clinic/Appointment notes
- ☐ Operative/Procedure reports
- ☐ Social needs screening
- ☐ Emergency Dept visit notes
- ☐ Lab/diagnostic test results
- ☐ Pathology reports
- ☐ Billing
- ☐ Discharge Summary notes
- ☐ Radiology results/films
- ☐ Therapy notes (PT/OT)
- ☐ Other: ______________________

E. Purpose of this Release Information

- [ ] Personal/At my request
- [ ] Consultation/Continuity of Care
- [ ] Disability
- [ ] Transfer of Care to another provider
- [ ] Insurance
- [ ] Legal
- [ ] Other: ____________________

F. How Information may be Communicated

- [ ] Email
- [ ] In-person
- [ ] Fax
- [ ] Other: ____________________

G. Date Range of Information to be Disclosed/Received

FROM: ____________________ **TO:** ____________________

H. DISCLOSURES

REVOCATION	I understand I may revoke this authorization at any time by providing written notice to the agency noted above. I understand that any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to privacy.
EXPIRATION	➜ **This authorization will expire in 90-days from the date of consent OR on (specify date):** ____________________
AUTHORIZATION	• I hereby authorize the above agencies to disclose health and social needs information concerning the above named patient to the parties identified in the section entitled “CI. Authorized to Disclose Information TO” and “DI. Authorized to Receive Information FROM.” • I understand the information to be received and/or released may include information regarding treatment of mental health, alcohol and drug use, and HIV (human immunodeficiency virus), AIDS (acquired immunodeficiency syndrome) related information. • I understand once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. • I further understand that I may refuse to sign this authorization and my refusal will not affect my ability to obtain treatment, or payment or eligibility of my benefits. • **A photocopy/fax of this authorization will be treated in the same manner as an original.**
CONSENT	____________________ Patient Signature OR Signature of Person Authorizing Consent if acting on behalf of a minor ____________________ Date of Consent ____________________ Relationship to Patient, if signing on behalf of the patient **I understand I am not required to sign this Release of Information if I do not wish to release my records.** **I understand my ability to receive services may be limited if a Release of Information is not signed, allowing agencies to communicate on my behalf, or on behalf of the patient if the patient is a minor.**

COMMENTS (specify section to which comments apply): ____________________

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Initials ____________________