The Women's Clinic of Northern Colorado

1107 S Lemay Ave, Suite 300 • Fort Collins, Colorado • 80524
Telephone 970-493-7442 • Fax 970-493-2990
womensclinicnoco.com

Now able to submit this request electronically
Upload form to our website at
womensclinicnoco.com
Via the Upload Records / Documents link
In the upper right-hand corner

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ FORMER NAME: _____
BIRTHDATE:_____ SOCIAL SECURITY NO.:_____
CURRENT ADDRESS:_____ PHONE:_____
_____

THIS AUTHORIZATION APPLIES TO THE FOLLOWING INFORMATION:

□ Complete Health Record
□ Last 2 years of Health Record
□ History and physical exam
□ Laboratory test results
□ Photographs, U/S
□ Diagnosis and treatment codes
□ Consultation reports
□ X-ray reports
□ Complete billing record
□ Other, please specify:_____
□ Discharge summary
□ Progress notes
□ X-ray films / images
□ Itemized bill

□ **EXCLUDE INFORMATION RELATING TO**:_____

PURPOSE OF REQUEST:

□ Treatment or consultation
Date of Appointment: _____
□ Disability: (circle) Surgery / Pregnancy Dates of disability period _____
□ At the request of the patient
□ Transfer of care
□ Billing or claims payment
□ Litigation
□ Other: _____

I understand that these records may contain information regarding the **diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse or treatment, mental illness, psychiatric treatment or Hepatitis B or C testing. I give my specific authorization for these records to be released**. Initial if you decline_____ the release of these specific records.

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at The Women's of Northern Colorado, 1107 S. Lemay Ave., Suite 300, Fort Collins, CO 80524. Unless revoked, this authorization will expire 90 days from the date of signature.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Reliability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form. I can view or receive a copy of the protected health information to be used or disclosed. **I authorize The Women's Clinic of Northern Colorado to use and/or disclose the protected health information specified above.**

There is a charge for copies of records from The Women's Clinic. The charge for records is a flat fee of $18.53 for the 1st 10 pages, then $0.85/page for pages 11-30, and $0.57/page for pages 31 and above. This charge is for patients and personal representatives under the HIPAA Privacy Rule. The Colorado Medical Society Standard is applied to all other parties. You will receive an invoice for this service from either The Women's Clinic of Northern Colorado or HEALTHPORT.

_____ REQUEST FOR MEDICAL INFORMATION
(records from another facility to send to WCNC:
1107 S Lemay Ave, Ste 300, Ft. Collins CO 80524)
From Doctor: _____
Address: _____
City/State: _____
Phone: _____
Fax: _____

_____ AUTHORIZATION TO RELEASE
(for WCNC, 1107 S Lemay Ave, Ste 300, Ft. Collins, CO 80524 to send to another facility, as follows)
Send To: _____
Address: _____
City/State: _____
Phone: _____
Fax: _____

_____ _____
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATE SIGNED

_____
WITNESS