7353 SISTERS GROVE, COLORADO SPRINGS, CO 80923
Phone: 719-444-8484 x3115 Fax: 719-574-8799
Medical.Records@PeakviewBH.com

Authorization for Disclosure of Health Information

I hereby authorize _____Peak View Behavioral Health_____ to release medical information from the records of:

Patient Name: _____ **D.O.B.:** ____/____/_____ **SS#:** _____
Patient Street Address: _____
City: _____**State:** _____ **Zip Code:** _____

Date(s) of Treatment Requested: _____
Information to be disclosed (check all applicable items to be released):

- ☐ Discharge Summary ☐ Comprehensive Psychosocial ☐ Discharge Aftercare
- ☐ History and Physical ☐ Psychiatric Evaluation ☐ Nursing Assessment
- ☐ Other (please specify):_____

Purpose Or Need For The Disclosure Is:

☐ Continued Medical Care ☐ Insurance ☐ Legal ☐ Patient's Own Use ☐ Other _____

The Information May Be Disclosed To:

Recipient's Name: _____
Street Address: _____
City: _____**State:** _____**Zip Code:**_____

Phone #: _____**Fax #:** _____

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, and enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ **or upon the following event:** _____
(Date)
(If no date or event is specified, this authorization will expire in six months from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws. I understand medical records has 30 days to process this request.

_____ _____
(Signature of Patient or Personal Representative)* *(Date of Signature)*

***If signed by a personal representative, a description of the representative's authority to act is as follows:**

☐ **Parent** ☐ **Legal Guardian** ☐ **Health Care Power of Attorney**
☐ **Administrator** ☐ **Executor of Estate** ☐ **Next of Kin** ☐ **Beneficiary**