COLORADOSCHOOLOFMINES

Coulter Student Health Center
1770 Elm St.
Golden, CO 80401
Phone: 303.273.3381 Fax: 303.273.3623

Name:______________________ Birthdate:________________ CWID#:________________

I hereby authorize The Coulter Student Health Center to _________Disclose _________Receive the following protected health information:

____Operative notes/reports ____X-ray reports ____Psychiatry intake and progress notes
____Physician progress notes ____Lab/test results ____Other____________________________

Purpose of Release: The protected health information will be used or disclosed for:
____Ongoing treatment and care ____Specialist referral ____Other_________________________

Receiving Party: Coulter Student Health Center may **release** the requested health information to:
Name:____________________________ Phone:_____________________ Fax:_________________
Address:________________________________ City__________________ State:_____ Zip:_______

Releasing Party: Coulter Student Health Center may **receive** the requested health information from:
Name:____
Phone:_________________________________ Fax:______________________________

Expiration: This authorization will expire in one year from the date of signature, or ________________ (event that relates to the patient or the purpose of the disclosure).

Revocation: Patient may revoke this authorization in writing at any time, except to the extent that the Coulter Student Health Center has acted in reliance on this authorization. Revocation must be made in writing and delivered to the Privacy Officer.

Redisclosure: Information used or disclosed under this authorization will be given to recipients who may redisclose the information and those later disclosures may not be protected by law.

Patient's Rights: The patient may inspect or copy the protected health information used or disclosed pursuant to authorization and may refuse to sign this authorization. Except where allowed by law, CSM Coulter Student Health Center will not condition treatment or payment of other health care benefits on the giving of this authorization. The patient shall receive a copy of this authorization if requested.

_________________________________ __________________
Patient or Personal Representative Date

(Personal Representative is a person authorized by law to make health care decisions on behalf of the individual: parent, guardian, Durable Power of Attorney for Health)

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Description of Personal Representative's Authority