CSU HEALTH NETWORK

CARE FOR BODY AND MIND

Medical Records (970) 491-2349 Fax: (970) 491-0226

Medical Services (970) 491-7121
Counseling Services (970) 491-6053
Health Education and Prevention Services (970) 491-1702
health.colostate.edu

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. All records from outside providers that have been accepted as a part of the permanent record set will be included in the release.

o I request that CSU Health Network release my records to the following person or facility:
o 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

oLimited to records regarding specific illness/injury/mental health (state condition or approximate dates).

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o Medical Records o Psychiatric Records
o Genetic Testing oLab Only
o Billing oX-Ray CD Only
o Counseling Records oLearning Disability/ADHD Evaluation
oOther____

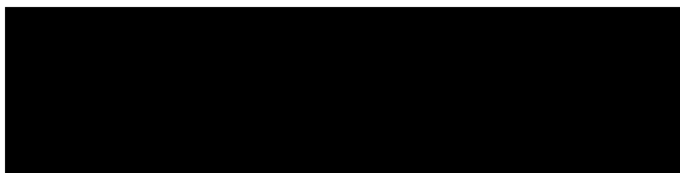
PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSE(S):

oAttorney oPersonal Records oInsurance oContinuity of Care / Another Care Provider

oOther____

☐ I understand there is a charge for records copied/summarized for personal, attorney or insurance purposes this excludes continuity of care record requests for all medical facilities. Based on Colorado State Statutes, the charge for copying is $14.00 for the first 10 pages; $0.50 per page for pages 11-40; and $0.33 for each additional page. The CSU Health Network charge for summaries is $25.00. The charge for an X-ray CD not related to a referral is $6.00. If you receive a summary and copies of records, you will be charged both fees.

1. ***I understand 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 authorizing the use or disclosure of the information identified above 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.

3. 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.**
4. 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.
5. 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.
6. 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	Time

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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. _______