

I authorize Little Colorado Medical Center to disclose protected health information ("PHI") from the health records of:

Patient name:	Date of BirthPhone number:	
Address:		
	[date] to	[date] to be disclosed to
	at	[address];
[phone number if known;	fax number if known].
Specific description of the information		
Discharge SummaryOperative Reports	History and Physical ExamX-ray Reports	
Lab Tests	Other (specify)	
Specific description of the purposes of Continued Patient Care	of the disclosure: Workers' Compen	sation
Insurance Coverage/Payment The disclosure is at my (the pa	for CareOther (specify)	
AIDS/HIV and other Communi Behavioral Health Care/Psychi Alcohol and/or Drug Abuse Tre	lose information related to (check all that applicable Diseases iatric Care/Mental Health Information eatment (in compliance with 42.CFR §2.31-§2.36)	•
I also understand that I may revoke this a revoke this authorization, I can read the part of the revoke my authorization, I must subm	if I do not wish to sign this form. I understand that authorization at any time, with some exceptions. provider's Notice of Privacy Practices. In a written request to the Medical Record Depart g unless otherwise specified	For more details on when I can and cannot tment. Unless I revoke this authorization earlier
	sclosed to a third party, the information may no lo he person or organization that receives the inform	
	his form. I release the provider, its employees, off onsibility or liability for the disclosure of the above	
O'mateur (Paliat	Poly	Staff Use Only
Signature of Patient	Date	Acct#
Signature of Legal Representative	Relationship to Patient or Description Authority to Act for Patient	†H&P Progress Orders ↑ Lab/EKG †X-ray ENTIRE
Patient Consent verified		OtherHANDED/MAILED/FAXED
Identification verified		Date:
		Ву: