

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

Patient name:	Date of Birth		
Address:	Phone number:		
I authorize PHI from	[date] to	[date] to be dis	closed to
	at	[address];
[p]	none number if known;	fax number if knowr	ı].
Specific description of the information Discharge Summary Operative Reports Lab Tests	to be disclosed: History and Physical Exam X-ray Reports Other (specify)		
Specific description of the purposes of Continued Patient Care Insurance Coverage/Payment fo The disclosure is at my (the pati	or CareOther (specify)	1	
AIDS/HIV and other Communica Behavioral Health Care/Psychia Alcohol and/or Drug Abuse Trea	se information related to (check all that apply): able Diseases tric Care/Mental Health Information ttment (<i>in compliance with</i> 42.CFR §2.31-§2.36)		
The provider will not deny me treatment if	I do not wish to sign this form. I understand that I ma	ay refuse to sign this autl	norization form.
	thorization at any time, with some exceptions. For n	nore details on when I ca	in and cannot
revoke this authorization, I can read the pr			
	a written request to the Medical Record Department. unless otherwise specified		thorization earlie
	losed to a third party, the information may no longer e person or organization that receives the informatior		ral privacy
	form. I release the provider, its employees, officers sibility or liability for the disclosure of the above infor		
Signature of Patient	Date	Staff Use Only	
		Acct#	
Signature of Legal Representative	Relationship to Patient or Description of Authority to Act for Patient	Face Sheet fT-sheet x2 EMS fD/C fH&P Orders ↑	Operative Pathology Med Record N Notes Progress Lab/EKG
		tX-ray tOther	ENTIRE
atient Consent verified		HANDED/MAILED/FAXED	
dentification verified		Date:	
		Ву:	
Reviewed 08/2022			