Cordant Health Solutions
12015 E. 46th St., Ste 650
Denver, CO 80239
Tel. 1-800-282-6574
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name (print): _____ Patient's Date of Birth: _____
Today's Date: _____

NOTICE: Patients have the right to request, in writing, to inspect, have access to or obtain copies of protected health information (PHI) that Cordant Health Solutions maintains. THIS FORM MUST BE COMPLETED IN ITS ENTIRETY TO BE CONSIDERED VALID.

Please place a check in box(s) below to identify the information you are requesting (more than one option may be checked):

☐ All health information maintained by Cordant ☐ All Laboratory Test Reports ☐ All Billing and Claims Reports
☐ Date range: _____**to**_____ ☐ Specific Accession Number(s): _____
☐ The following specific information: _____

The purpose for this release of information is (more than one option may be checked):

☐ To complete insurance process ☐ For legal reasons ☐ For personal reasons
☐ To continue medical care ☐ Other: _____

Please indicate below how you would like to receive this information:

☐ Review the information on-site at Cordant Health Solutions
☐ Send a photocopy of the information to (name of person/entity): _____
Address/Fax Number/**Encrypted** Email: _____
☐ By checking this box, I am further authorizing Cordant to discuss my PHI with the person/entity named above.

Continuing Services: I understand the provision of healthcare service by Cordant is not dependent on this authorization and I am not required to sign this authorization; however the information will not be disclosed without it. I understand that if anyone who receives my health information is not a health care provider or a health plan, federal privacy laws may no longer protect that health information.

Charges for Access: If you ask us to copy your health information, there is no cost for requests that can be completed within twenty (20) minutes. The cost for requests that require more than twenty (20) minutes to complete will be determined on a case-by-case basis. Postage, overnight delivery and electronic media charges may apply.

Authorizing Request: By submitting this form, I hereby request Cordant provide me or the named person/entity above with access to and/or a copy of my PHI maintained by Cordant.

Revocation: I understand I have the right to revoke this authorization in writing at any time, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending written correspondence to Cordant.

Photo Identification: The patient should include with this form a copy of government issued identification such as, but not limited to, a driver's license, military identification, or passport.

_____ _____
Date Signature of Patient

This authorization form expires on this date_____ OR at the completion of this event: _____.
If the expiration date or event is left blank, this authorization form will automatically expire in 90 days.

Patient's Personal Representative: If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient named above and I am not prohibited by Court Order from authorizing disclosure of the requested information.

_____ _____
Date Signature of Parent or Legal Representative

Office Use Only - Date form received: _____