



Cordant Health Solutions
Attention: Records Request
12015 E. 46th St., Ste. 220
Denver, CO 80239
Tel. 1-800-282-6574
Fax: 1-303-371-0583

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name (print):
Today's Date:

Patient's Date of Birth:

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:
Pharmacy Records

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: