Part A: Patient Information

Patient #:

Patient Last Name	Patient First Name	M. I.	Patient Date of Birth

Street Address, Apt/Unit #	City	State	Zip Code

Cell Phone #	Home Phone #	Email Address

Part B: Who Can See My Records

The people listed and checked below have the right to see my records (they must be 18 or older).
Please check each box that applies.

☐ **Information is NOT to be shared with anyone.**

FIRST & LAST NAME	RELATIONSHIP TO PATIENT	CONTACT #

☐ **All my health and financial records.** This may include records about your health, diagnosis, names of doctors or other healthcare providers, financial, insurance, and appointments.

OR

☐ **Only some records** (check all that apply):

☐ Doctor/Hospital Notes ☐ Diagnosis (name of illness) ☐ Financial (bills, claims, & payments) ☐Eligibility/Benefits
☐ Referral(s) (to see a specialist) ☐ Treatment(s) ☐ Pharmacy ☐ Other: _____

CPP may share my sensitive data which could include information such as personal details about substance abuse, family planning, reproductive health, and mental health. Check all boxes that apply:

☐ **Sensitive information is NOT to be shared with anyone.**

OR

☐ **All sensitive records.**

OR

☐ **Only some sensitive records** (check all that apply):

☐ Abuse (sexual/physical/mental) ☐ Substance Use Disorder/SUD (alcohol or drug) ☐ Mental Health
☐ Pregnancy/Abortion ☐ HIV or AIDS ☐ Mental Health ☐ Genetic Testing ☐ Sexual Diseases passed to other

☐ **Other Request(s):** _____

Why you want your records shared (check only one box):

☐ For the reasons shown on this form **OR** ☐ Special reason(s): _____

Expiration: This authorization will expire (check one): ☐ Fulfillment of the Request **OR** ☐ Date: _____

This section only needs to be reviewed and filled out if you want to share substance use (SUD) records:

1. Unless I specify otherwise on this form, this disorder includes all my SUD records maintained by CPP. I understand that my SUD records are protected under federal law, including the federal regulations governing confidentiality (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and cannot be disclosed without my written consent. I understand that I may revoke this authorization at any time.
2. Specify time period of records to be disclosed: _____
3. Description of records that may be disclosed: _____

Part C: Named Legal Person or Guardian

(only complete this section if you have documentation supporting legal representation)

If there is a person who is signing for the patient (someone who takes care of the patient), one of the following is **required**:

- A copy of health care, general, or durable power of attorney **OR**
- A court order or other proof (this will show someone has the legal right to care for a person; other proof can be legal forms that show someone can, by law, act for the patient)

Legal Representative for Patient (print full name)

Relationship to Patient

Legal Representative Street Address, Apt/Unit #

City

State

Zip Code

Legal Representative Signature

Date

Part D: Acknowledgement of Notice of Privacy Practices and HIPAA

☐ I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

☐ I hereby acknowledge that I have read the Notice of Privacy Practices, which is available electronically on the Colorado Physician Partners website. I can also obtain a copy at the practice.

Part E: Patient/Patient Representative Signature

I have read and reviewed each part of this form and attest to the accuracy. I know, agree, and will allow CPP to use and give out my records as I have stated above. I acknowledge I signed this form of my own free will. I know I do not need to sign this form to receive treatment. I have the right to revoke what I agreed to in this form at any time and will notify CPP in writing. I know taking this back will not change any action taken before I do so. Once records are released, they may be shared by the recipient and are no longer be protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Patient/Patient Representative Signature

Date

You have the right to keep a copy of this form after you finish filling it out.

***NOTE:** For your convenience, information provided will be updated across all Colorado Physician Partners systems.