Harmony SURGERY CENTER
2127 East Harmony Road, Suite 200 · Fort Collins, CO 80528
(970) 297-6300 · www.harmonyasc.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. **Patient's Name**:_____ **Date of Birth**:_____
2. I hereby authorize the release of my Protected Health Information (PHI) FROM:_____

FROM:	**TO:**
Name / Title Harmony Surgery Center, LLC	**Name / Title**_____
Address 2127 East Harmony Road, Suite 200	**Address**_____
Phone 970-297-6300 **Fax:** 970-297-6351	**Phone**_____ **Fax:**_____
*Date Received:*_____ *By Whom:*_____ *(For Internal Use Only)*	*Date Released:*_____ *By Whom:*_____ *(For Internal Use Only)*

3. **DATE(S) OF SERVICE REQUESTED:**_____
4. **INFORMATION REQUESTED:**
   - ❑ Complete copy of medical record (all pages)
   - ❑ Other – Specify: _____
5. **PURPOSES FOR WHICH INFORMATION IS TO BE USED:**
   - ❑ Further Evaluation
   - ❑ Insurance/Reimbursement
   - ❑ Other
   - ❑ Legal
   - ❑ Verify Treatment Status
6. **EXPIRATION DATE:** This authorization expires one year from date of signing unless otherwise stated here._____
7. **RIGHT TO REVOKE:** I understand that I have the right to revoke this Authorization in writing at any time subject to the exceptions stated below. To revoke this Authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific Authorization. In addition, I must sign my request and then mail or deliver my request to **Medical Records Department of Harmony Surgery Center, LLC (HSC).**

   Exceptions to Right of Revoke: I understand that my written request to revoke this authorization will not affect the ability of **HSC** to continue to use or disclose my health information to the extent that is has already been acted in reliance on this Authorization.
8. **PAYMENT**: According to Colorado State Statutes, **HSC** may charge reasonable fees for copies of medical records. Alternatively, we may provide you with a summary of explanation of your health information as long as you agree that, and to its cost, in advance. If you indicate above that you would like a summary of your health information, we will inform you of the cost for that summary prior to providing you with the summary. If you do not agree to the charge, we will not prepare the summary.
9. **POTENTIAL FOR REDISCLOSURE**: Your health information disclosed according to this authorization will no longer be protected by the federal privacy law (known as "HIPAA"), and the recipient of the information may potentially redisclose it.
10. **THIS AUTHORIZATION IS BINDING**: The statements made in this Authorization are binding, controlling and I understanding that they take precedence over statements made in Notice of Privacy Practices.
11. **PLEASE PROVIDE A COPY OF YOUR VALID PHOTO ID**. This may include: Driver License, State Issued ID, Legal Citizen Identification, Passport or Millitary ID
    - ❑ Proof of Identification received

Authorization must be signed by the patient or by parent/legal guardian of a minor, or by the legal representative when the patient lacks the decisional capacity, or if the patient is physically unable to sign but mentally understands the consent.

Authorization Approval & Receipt of Acknowledgement: I hereby authorize the use or disclosures of my personal health information described in this authorization and acknowledge receiving a signed copy of this authorization. I understand that if anyone who receives my health information is not a healthcare provider or a health plan, my health information may not be protected by federal privacy laws if my health information is redisclosed by that recipient person or HSC**.**

Patient's Signature:_____ Date:_____

Address:_____

Phone Number:_____ Proof of ID if available:_____

Authorized Representative Name_____ Relationship to Patient:_____
Please Print Parent/Legal Guardian

Authorized Representative's Signature:_____ Date:_____

Witness Signature:_____ Date:_____