PATIENT STICKER

Boulder Valley Health Center
Your Community Reproductive & Sexual Health Clinic

Release of Information Authorization Form

Patient Name: _____ DOB: ____/____/_____

1. **I hereby authorize the release/disclosure of the following specified information.**
   - ☐ **ONLY** the following: all Pap results including high-risk HPV and Colposcopy.
   - ☐ Most recent annual exam, including chart notes, lab work, and Pap results
   - ☐ All health information in patient's medical record at the facility
   - ☐ Other: _____
2. ***Unless I have initialed below, I do not authorize the release of information regarding the following conditions:***
   ____ Substance Use ____ Psychiatric/Mental Health
   ____ Alcohol Use ____ HIV status
3. **Purpose of release:**
   ☐ Continuing medical care ☐ Personal Use ☐ Insurance ☐ Legal
   ☐ Other: _____
4. **Check one ☐ TO / ☐ FROM:**
   Boulder Valley Health Center | 2855 Valmont Road, Boulder, CO 80301
   Phone: (303) 442-5160 | Fax: (303) 440-8769
   Check one ☐ TO / ☐ FROM:
   Facility/Provider: _____
   Address: _____
   City/State/Zip: _____
   Phone: _____ Fax: _____
5. ☐ **By checking this box, I authorize sending this release and my health information via fax and indicate understanding:**
   - ☐ A copy of this authorization shall be utilized with the same effectiveness as the original.
   - ☐ I understand that I may revoke this authorization at any time as stated in notice of health info practices.
   - ☐ I further understand that any such revocation does not apply to the extent that people authorized to use or disclose my health information have already acted in reliance on the authorization.
   - ☐ I understand that this authorization will expire a year from signing this form.
   - ☐ I understand that charges may be incurred - $10 for flash drive with medical records.
   - ☐ (if applicable) I understand my substance abuse disorder records are protected under the federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be redisclosed without my written authorization.

X _____ _____/_____/_____

Patient Signature **Today's Date**