SOUTHERN UTE HEALTH CENTER

Authorization to Release Information FROM the Southern Ute Health Center

Name:	**Date of Birth:**
Last four of Social Security #:	**Daytime Phone#**

INFORMATION IS TO BE DISCLOSED BY:	**INFORMATION IS TO BE PROVIDED TO:**
Name of Organization/Facility Southern Ute Health Center	**Name of Organization/Facility**
Address 69 Capote Dr., PO Box 899	**Address**
City, State, Zip Ignacio, CO 81137	**City, State, Zip**
Phone/Fax 970-563-4581/970-563-0206	**Phone/Fax**

PURPOSE OF THIS DISCLOSURE:

- ☐ **Further Medical Care**
- ☐ **Disability Determination**
- ☐ **Legal Investigation**
- ☐ **Payment of Claim/Benefits**
- ☐ **Personal Use**
- ☐ **Other (specify)**

INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD (check appropriate boxes):

- ☐ **Only information related to (specify)** _____
- ☐ **Only the period of events from** _____
- ☐ **Other (specify)** _____
- ☐ **Entire Record**

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

- ☐ **Alcohol/Drug Abuse Treatment/Reference**
- ☐ **Sexually Transmitted Disease**
- ☐ **Psychotherapy**
- ☐ **HIV/AIDS Related Treatment**
- ☐ **Mental Health (Other than Psychotherapy Notes)**

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Right to inspect or **receive** a **copy of the information to be used or disclosed:** I understand that I have the right to inspect or receive a copy of the health information I have authorized lo be used or disclosed

Right to receive a copy of this authorization: I understand that if I agree to sign this authorization, which I am not required to do, I may request a signed copy of the form.

Right to **refuse to sign this authorization:** I understand that I am under no obligation to sign this form and the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment or eligibility for health care benefits based on my decision to sign this authorization.

Right to withdraw this authorization: I understand that written notification is necessary to cancel this authorization.

Expiration Date: This authorization is effective for one (1) year from the date signed unless otherwise indicated.

Date (Optional) _____

Patient or Legal Representative Signature/Relationship **Date of Signature**