release of information

New Phase Navigation
Mind, Care, Community.

Patient Information.

Patient Name _____ DOB: _____
Mailing Address: _____ Line 2 _____
City _____ State _____ Zip Code_____
SSN # _____ / A# _____
Phone: _____ (primary) _____
E:mail: _____ Fax: _____

Authorization. I request that New Phase Navigation, L.L.C. receive / disclose (circle one) information to/from:

Name of Authorized Person(s) _____
Agency / Organization _____
Phone Number_____ Fax: _____
E-mail _____

Information to be Released..

All of my medical information

My medical information only related to the following events::
_____
_____

From the following dates: _____ to _____

Duration.
This authorization expires on: _____ . If unspecified, this authorization shall remain in effect for 365 days from the signing of this document, unless revoked in writing prior to the date of expiration.

By signing this form, I consent to the release of information as indicated in this form for use by the requesting agency. I understand that my records are protected under Federal and State regulations governing confidentiality (HIPAA) and cannot be released without my written consent or that of my agent. I understand that any agency or individual using the above noted confidential information will take all necessary steps to protect the confidentiality of said information. I understand that I have the right to revoke this consent at any time, except for what has already been released at the time of revocation, by notifying New Phase Navigation and the Authorizing Party in writing. I acknowledge that I am entitled to receive a copy of this signed form. I understand that I have a right to refuse to consent to release of my confidential information.

_____ _____
Signature of Patient / Authorized Agent Date

_____
Relationship to Patient

References: https://www.hipaajournal.com/hipaa-release-form/
https://cdpsdocs.state.co.us/oajja/ccyis/Colorado_Consent_2016_V1_1.pdf