Cordant Health Solutions®

Denver, CO	Flagstaff, AZ	Tacoma, WA
12015 East 46th Ave.	1760 East Route 66	2617 East L Street
Suite 650	Suite 1	Suite A
Denver, CO 80239	Flagstaff, AZ 86004	Tacoma, WA 98421
P: 800-282-6574	P: 800-348-4422	P: 253-328-7932
F: 303-460-7502	F: 509-471-0135	F: 253-295-5404

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient's Name (Print): _____ **Patient's Date of Birth:** _____

Today's Date: _____ **Phone Number:** _____

Mailing Address: _____ **City:** _____

State: _____ **ZIP:** _____

NOTICE: THIS FORM MUST BE COMPLETED IN ITS ENTIRETY TO BE CONSIDERED VALID.

Please place a check in box(s) below to identify the information you are requesting (more than one box may be checked):

☐ All health information maintained by Cordant ☐ All laboratory test results ☐ All billing and claims reports

☐ Date range: _____ to _____ ☐ Specific Accession Number(s): _____

☐ The following specific information: _____

The purpose for which this release of information is (more than one box may be checked):

☐ To complete insurance process ☐ For legal reasons ☐ For personal reasons

☐ To continue medical care ☐ Other: _____

Please indicate below how you would like to receive this information:

Send a photocopy of the information to (**name of person/entity**): _____

☐ Address: _____

☐ Fax Number: _____ (records over 20 pages will be sent by US Mail/FEDEX)

☐ Email: _____ (all records sent by email will be encrypted for security purposes)

This authorization form will expire on _____.
(If the expiration date is left blank, this authorization form will automatically expire in 90 days.)

Continuing Services: I understand that the provision of healthcare service by Cordant is not dependent on this authorization and I am not required to sign this authorization; however, the information will not be disclosed without it. I understand that if anyone who receives my health information is not a health care provider or a health plan, federal privacy laws may no longer protect that health information.

Charges for Access: If you ask us to copy your health care information, there is no cost for requests that are under ten (10) pages. Requests that are over ten (10) pages will be charged $.20 per page if sent by mail. No charges will incur for records sent electronically. Additional charges for postage, overnight delivery and rush delivery charges (needed prior to 3 business days) may apply. Any charges that may apply are due prior to sending of records.

Authorizing Request: By submitting this form, I hereby request Cordant to provide me or the named person/entity above with access or copies of the PHI maintained by Cordant.

Revocation: I understand I have the right to revoke this authorization in writing at any time, except to the extent information has already been released pursuant to this authorization at the time of the revocation. I can revoke this authorization by sending written correspondence to Cordant.

PHOTO IDENFICATION: The patient MUST include with this form a copy of government issued identification such as, but not limited to, a driver's license, military identification, or passport.

_____ _____

Date **Signature of Patient**

Patient's Personal Representative: If the patient is a minor or has a personal representative, I represent that I am the legal parent/guardian/personal representative of the patient named above and I am not prohibited by Court Order from authorizing disclosure of the requested information.

_____ _____

Date Signature of Parent or Legal Representative