Howard Dental Center
SAVING LIVES ONE SMILE AT A TIME
6260 E. Colfax Avenue, Denver, CO 80220
Phone 303.863.0772 ◆ Fax 303.832.7823

CONSENT TO RELEASE INFORMATION

I, or my authorized representative, voluntarily consent to Howard Dental Center to release, receive, and discuss health information regarding my care and treatment as set forth on this form:

Authorizing person _____

Date of Birth _____ Name (Physician/Other) _____

Phone _____ Hospital/clinic/agency _____

Address _____ Phone _____

City, State & Zip _____ Date of Expiration _____

In accordance with Colorado State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Federal Law 42 C.R.S. Part 2.

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV-RELATED INFORMATION only if I place my initials on the appropriate line in Item 7 and I specifically authorize release of such information to the hospital/clinic above.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release of disclosure of HIV-related information, I may contact the Colorado Civil Rights Division at 303-894-2997 or toll-free at 1-800-262-4845.
3. I have the right to revoke this authorization at any time by writing to the healthcare provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.
6. Reason for disclosure:

❑ Continuity of care ❑ Other _____

7. **Specific information to be released and/or discussed: From Date_____ to Date _____**

❑ Laboratory Results ❑ Xray Reports
❑ HIV/AIDS information ❑ Other
❑ Most current medication list _____
❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other healthcare providers.

(Initial) _____ HIV related _____ Substance use _____ Mental health

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Sign Name _____ Sign Name _____
Patient or Patient Representative *Witness*

Print Name _____ Print Name _____

Date: _____ Date: _____