University of Colorado Colorado Springs

Patient Name(s):

Contact Phone #:

Date of Birth: Medical Record #:

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Please check if you are requesting information be released (TO) and /or obtained (FROM) by UCCS HealthCircle Clinics.

TO: ☐ FR: ☐ The Aging Center (719) 255-8002 (719) 255- 8006 Fax	TO: ☐ FR: ☐ Center for Active Living (719)255-8004	TO: ☐ FR: ☐ Peak Nutrition Clinic (719) 255- 7524
TO: ☐ FR: ☐ Veterans Health and Trauma Clinic (719) 255- 8003 (719) 255- 8075 Fax		TO: ☐ FR: ☐ Primary Care Clinic (719) 255- 8001 (719) 255- 8044 Fax

Please check if you are requesting information be released (TO) and/or obtained (FROM) another provider.

☐ ☐ Obtain From: (Releasing facility) ☐ ☐ Release To: (Receiving entity)

Provider Name:_____

Address:_____

City, State, Zip_____

Phone:_____Fax:_____

The Purpose for this Release:
- ☐ Continuity of Care
- ☐ Damage/Claim Information
- ☐ Personal Use
- ☐ Legal
- ☐ Coordination of Care
- ☐ Other

INFORMATION TO BE RELEASED AND / OR OBTAINED (CHECK ALL THAT APPLY):

☐ Emergency Room Report	☐ Mental Health Treatment Plan(s)	☐ Mental Health Treatment Summary
☐ Discharge Summary	☐ Drug/Alcohol Treatment	☐ HIV/AIDS Information
☐ Radiology Reports/Images	☐ Psychological/Neuropsych Testing	☐ Genetic Information
☐ History and Physical	☐ Laboratory Reports	☐ Other: _____

Date of Service Range (month/year): From:_____ To:_____

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand this authorization is voluntary, and further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed and THERE MAY BE A COST TO COPY THE RECORDS OR WRITE A TREATMENT SUMMARY.

I understand there are limited exceptions to these provisions in the Colorado Statues. These require reporting of threats of violence, harm, or child or elder abuse and neglect (from either evidence or suspicion), or when subpoenaed by the courts, to proper authorities. Certain other exceptions exist and will be explained as necessary.

I understand that this consent expires one year from the date of my signature or 6 months from the last appointment unless otherwise specified as follows: _____

I understand I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date of this authorization. A copy, fax, or scan of this form is to be considered as valid as the original.

_____ _____

Signature of Patient or Authorized Representative Date of Signature

_____ _____

Printed Name Relationship to Patient (if applicable)

Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated above:

_____ _____

Signature of Patient or Personal Representative Date

University of Colorado Colorado Springs

Health Circle at Lane Center
4863 N Nevada
Colorado Springs, CO 80918

REFERRAL FORM

CONTACT INFORMATION: (PLEASE PRINT) Today's Date: _____

Patient's Name: _____
Last First Middle Initial

Parent/Guardian's Name:_____
Last First Middle Initial

Insurance and Group #:_____

Veteran: ☐ **Yes** ☐ **No** ☐ **Dependent**

Best Contact Number: _____ OK to Leave a message? ☐ Y ☐ N

Email Address: _____

Date of Birth: _____ **Age**: _____ **Gender**: _____

Referring Provider Name and Contact information:

What are the key issues/concerns for which your client is seeking this referral:

Previous Treatment for referring issue? ☐ **Yes** ☐ **No**

If yes, briefly describe:

Please indicate services below that might benefit your client:
☐ Individual therapy ☐ Family therapy ☐ Couples therapy ☐ Group therapy (DBT, Mindfulness/Yoga)
☐ Neurocognitive Assessment ☐ Care Giver Support ☐ Active Living classes ☐ Nutritionist service ☐ Physical
☐ Other medical services: Please describe_____
☐ Other services: _____