



# COLORADO SCHOOL OF MINES

Coulter Student Health Center  
1770 Elm St.  
Golden, CO 80401  
Phone: 303.273.3381 Fax: 303.273.3623

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ CWID#: \_\_\_\_\_

I hereby authorize The Coulter Student Health Center to \_\_\_\_\_ Disclose \_\_\_\_\_ Receive the following protected health information:

\_\_\_\_ Operative notes/reports      \_\_\_\_ X-ray reports      \_\_\_\_ Lab/test results  
\_\_\_\_ Physician progress notes      \_\_\_\_ Entire record      \_\_\_\_ Other \_\_\_\_\_

**Purpose of Release:** The protected health information will be used or disclosed for:  
\_\_\_\_ Ongoing treatment and care      \_\_\_\_ Specialist referral      \_\_\_\_ Other \_\_\_\_\_

**Receiving Party:** Coulter Student Health Center may release the requested health information to:  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Releasing Party:** Coulter Student Health Center may receive the requested health information from:  
Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Expiration:** This authorization will expire in one year from the date of signature, or \_\_\_\_\_ (event that relates to the patient or the purpose of the disclosure).

**Revocation:** Patient may revoke this authorization in writing at any time, except to the extent that the Coulter Student Health Center has acted in reliance on this authorization. Revocation must be made in writing and delivered to the Privacy Officer.

**Redisclosure:** Information used or disclosed under this authorization will be given to recipients who may redisclose the information and those later disclosures may not be protected by law.

**Patient's Rights:** The patient may inspect or copy the protected health information used or disclosed pursuant to authorization and may refuse to sign this authorization. Except where allowed by law, CSM Coulter Student Health Center will not condition treatment or payment of other health care benefits on the giving of this authorization. The patient shall receive a copy of this authorization if requested.

\_\_\_\_\_  
Patient or Personal Representative

\_\_\_\_\_  
Date

(Personal Representative is a person authorized by law to make health care decisions on behalf of the individual: parent, guardian, Durable Power of Attorney for Health)

\_\_\_\_\_  
Description of Personal Representative's Authority