uchealth

Authorization to Disclose Protected Health Information
COVID-19 PCR Testing

Patient Identification Label
Name _____
MRN _____
DOB _____
Date of service _____

Patient name _____ Date of birth _____

I authorize representatives of UCHealth to disclose my protected health information ("PHI") as specified in this Authorization with the designated individuals set forth below.

I authorize the use and disclosure of my **COVID-19 PCR test results** to the following entities or individuals:

Colorado College

I understand the following:

1. I am authorizing the use or disclosure of my medical information, to include the results of my COVID-19 testing, to the above individuals/entities.
2. This authorization is voluntary and the disclosure is made at my request.
3. If the individual or organization authorized to receive the information is not a health plan or health care provider, the release or re-release of the information may no longer be protected by federal privacy regulations.
4. I need not sign this form to ensure health care treatment or payment for care.
5. I understand I have the right to revoke this authorization at any time by notifying UCHealth in writing at the following address:

   UCHealth
   Health Information Management
   12605 E. 16th Ave., Mailstop A025
   Aurora, CO 80045

   I further understand that the revocation is only effective after it is received by the above and that any use or disclosure made prior to the revocation under this authorization will not be affected by the revocation.
6. This authorization will expire one (1) year from the date set forth below.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Name of patient (printed)	Relationship to patient
Signature of patient or legally authorized representative	Date / Time

Interpretation: Discussion interpreted for patient/representative by (name) _____ (#)_____ (date/time)_____