RRCC Student Health and Counseling Center
13300 West 6th avenue
Lakewood co 80228-1255
Tel: 303-914-6655 Fax:303-914-6811

**AUTHORIZATION FOR RELASE OF INFORMATION**

Patient Name: _____ S-Number: _____

Date of Birth: _____ Phone Number: _____

Address: _____City: _____State: _____Zip: _____

**I authorize RRCC Student Health Clinic & Counseling Center to:**

☐ Release the following information: ☐ Receive the following information from:

Name of Facility/Person: _____

Address /City, State, Zip: _____

Fax Number (if information is to be faxed): _____

☐ The patient's entire medical record generated in this office

☐ Medical Data/Information related to:

Radiology(specify): _____ Laboratory Tests(dates)_____
Immunizations: _____ Gynecological, Inc. pap smear (dates)_____
Verbal Communication (visit date):_____ Other (specify) _____

The following information will not be release unless you specifically authorize it by checking the relevant box(es) below:

- ☐ Information pertaining to drug and alcohol Abuse
- ☐ Information pertaining to meet mental health
- ☐ Information pertaining to psychotherapy notes
- ☐ Release of HIV/AIDS testing results

**Purpose of Disclosure: (circle one)**

Healthcare Insurance Legal School Employment/Internship

This authorization will expire 6 months from the date it is signed unless a shorter time is indicated here: _____ You may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified, except to the extent disclosure made prior to receipt. Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected under Federal Privacy Regulations. RRCC Student Health and Counseling cannot require you to sign this Authorization as a condition to the Provision of service; however, your health care may be affected if your providers are not able to obtain information pertinent to your condition and treatment. You have a right to request a copy of this Authorization after signing it and agree to pay reasonable copying fees (incompliance with Colorado statute) if records are not being sent to another medical/mental health facility.

_____

Signature of patient or Legal Representative Date