Plume P.C.
Phone: 720-897-3749
Fax number: 720-815-0227
Address: 303 S Broadway
#200-357 Denver, CO 80209

Authorization to Release and Receive Protected Health Information By Patient or Legally Authorized Representative.

A health record is private and contains information known under the law as "Protected Health Information" (PHI). By completing and signing this form, I, or the person I am legally authorized to represent, agree to allow Plume P.C. to share my or the patient's PHI with the people or entities listed below. I agree that by Plume P.C., I mean all employees, staff, and other Plume personnel who have access to any health information, about me or the patient I represent, received or created in the provision of health care.

Patient Information:

Patient First Name:	*Patient Last Name:*	*Middle Initial:*	*Date of Birth:*
_____	_____	_____	_____

Plume can release my or patient's PHI to the following people or entities AND The following people or entities can release my or patient's PHI to Plume:

Person or Entity Name:	*Person or Entity Phone Number:*
_____ _____	_____
Person or Entity Address:	*Person or Entity Fax Number:*
_____ _____	_____

Information to be released and received, to and from, Plume and the people or entities listed on the previous page via mail/fax/phone:

Specific Information to be released:

(Check all that apply to agree to release information)

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, which includes patient history, provider visits, medications, diagnoses, and lab results.
- ☐ I agree to release information related to (OTHER, SPECIFY BELOW)

_____

I understand that information related to the following may only be released if I specifically order its release.

(Check all that apply, to agree to release information related to HIV, Substance Abuse, and/or mental health)

- ☐ Mental Health Information
- ☐ HIV-Related Information
- ☐ Alcohol/Drug Use and Treatment Information

This Protected Health Information is to be released for the following purpose(s):

_____

_____

_____

This authorization shall be in force and effect for 5 (five) years from the last date of healthcare service at Plume, at which point this authorization expires (unless effectively revoked in writing prior to expiration).

By signing below I understand and agree: Plume may release my or the patient's PHI within the terms outlined above. I have been given the opportunity to review Plume's Notice of Privacy Practices. I understand that I have the right to revoke this authorization, at any time, by sending notification to Plume through the patient communication platform, Spruce. I understand that a revocation is not effective to the extent that Plume has relied on my authorization to disclose protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal or state law. I understand that I have the right to refuse to sign this authorization and that my refusal will not affect my right to treatment.

Patient or Legally Authorized Representative Signature:

X_____

Print Name:	*Date:*	*Phone Number:*
_____	_____	_____

If a Legally Authorized Representative signed this form, describe the relationship: (e.g. parent, legal guardian, Power of Attorney, etc.):

Relationship to Patient: _____

If this request is being signed by a patient's Legally Authorized Representative, you must provide legal documentation authorizing you to act on the patient's behalf.