BELLA
health + wellness
WOMEN • MEN • CHILDREN

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE FILL OUT ALL FIELDS**

Allow 7-10 days to transmit your records from Bella Health to another provider.

I HEREBY AUTHORIZE:	**TO SEND MY RECORDS TO:**
	Bella Health + Wellness
Address:	Address: 180 E Hampden Suite 100
	Englewood, CO 80113
Phone:	Phone: 303-789-4968
Fax:	Fax: 303-789-6018
Is this a transfer of care? (Y/N)	

I. MY AUTHORIZATION

With my consent, **Bella Heath + Wellness** may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Bella Health + Wellness will be my primary care office.

PLEASE SEND A COPY OF THE FOLLOWING RECORDS (ANY OF WHICH APPLY):

*All my health information pertaining to these things below will be disclosed **EXCLUDING** (CHECK TO EXCLUDE):

- ❑ My health information related to drug abuse
- ❑ My health information related to alcohol abuse
- ❑ My health information related to HIV/AIDS
- ❑ My health information related to psychological or psychiatric conditions

*You may use or disclose the following health care information maintained by previous health care providers

- ❑ My Complete Records
- ❑ My Care Plan
- ❑ My Treatment Record
- ❑ My Lab Reports
- ❑ My Imaging Reports
- ❑ My Pathology Reports
- ❑ My Medication Record
- ❑ My Progress Notes
- ❑ Other: _____.

You may Disclose my health information relating to the following treatments or conditions:

_____

_____

Disclose my health Information from the dates: _____.

Reasons for this authorization (Check all that apply)

- ❑ At my request
- ❑ Other (Specify):

_____

II. My Rights:

I understand that I do not have to sign this authorization in order to get healthcare benefits (treatments, payment, or enrollment). However, I do have to sign an authorization form to:

- **To receive health care when the purpose is to create health information for third parties.**

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above name practice based upon this authorization, I may not be able to revoke this authorization if its purpose was to obtain insurance.
To revoke this authorization, write a letter to the office and it will be put into your chart.
Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Name (Please print):	**Former Name (If applicable):**	**Date Signed:**
Date of Birth:	**Signature Of Patient (Or Legally Authorized individual)**	**Relationship to Patient (If applicable)**

Record requests from Bella will be sent within 14 business days. Large or expedited files may result in a $30 fee.