Specialists in Prevention Diagnosis and Treatment of Adult Illness

AUTHORIZATION/RELEASE FOR PROTECTED HEALTH INFORMATION (PHI)

Patient Legal Name: ______________________________ Date of Birth: ______________________________

Social Security Number: ______________________________

Address: ______________________________ Phone Number: ______________

______________________________ ______________________________

City: ______________ State: ______________ Zip Code: ______________

______________ ______________ ______________

I hereby authorize the following facility to disclose Protected Health Information of the Patient listed above.

FROM: Facility/Doctor Name
Name/Title: ______________________________
Address: ______________________________
Phone: ______________________________

(MUST BE COMPLETE ADDRESS) TO:
Name/Title: ______________________________
Address: ______________________________
Phone Number: ______________________________
Fax Number: ______________________________

Reason to Release Protected Health Information:

____

Type of Access Requested: ______________________________

Specific Date Range Requested: ______________________________

□ Copies of Records

□ Entire Record
□ Pertinent Information ONLY
□ ER Records
□ History & Physical
□ Consult Report
□ Operative Report
□ Rehabilitation Services

□ Lab
□ Imagine/Radiology
□ Cardiac Studies
□ Demographics
□ Nursing Notes
□ Medication Record

□ Progress Notes
□ Physicians Orders
□ Billing Records
□ Immunizations
□ Other

Expiration: This authorization share expire (check one) *If notified out auth will expire one year from date signed:*

□ Fulfillment of this Request □ Date: ______________________

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
The facility will not condition treatment, payment, enrollment, or eligibility for benefits upon authorization unless specified use applies to specific exceptions.
I understand that there may be a fee involved with the fulfillment of this request. See fee schedule below.
I understand that the term Complete Chart for release of Protected Health Information mean that only records generated by this facility will be released.
I have read the above and authorize the disclosure of the protected health information.
For closed clinics, there will always be a fee for copying of records.

Signature of Patient/Parent/Legal Guardian: ______________________________ Date: ______________

Printed Name: ______________________________ Relation to Patient: ______________________

PATIENT FEE SCHEDULE

Fees for duplication of Protected Health Information being released directly to the patient will be charged the following, $.39 per page for pages 1-40 and $.36 per page for pages 41+. Actual postage or shipping costs and applicable sales tax, if any may be charged. Records may be requested and released by attorney will follow Colorado State Statute rates

*To ensure timely processing of medical records, please fill authorization out completely.