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Avon, CO 81620
Phone (970) 926-6340
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AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Release Medical Records FROM:

Send Medical Records TO:

Doctor / Hospital / Facility

Doctor / Hospital / Agency / Facility / Person

Street Address / City / State / Zip Code

Street Address / City / State / Zip Code

Phone Number / Fax Number

Phone Number / Fax Number / Email

RECORDS TO BE DISTRIBUTED BY:

Fax
 Mail (Paper Copy Encrypted CD)
 Encrypted Email
 Pick-Up (Avon Vail Eagle)

***I understand that my medical records may contain information concerning my mental health and/ or psychiatric treatment, drug and/or alcohol treatment as well as any HIV test results (AIDS).** Authorize Release Do NOT Authorize
 Not applicable

INFORMATION TO BE RELEASED (check all that apply):

Date of Service range (month/year): From: _____ To: _____
 Emergency Room Report Mental Health Treatment Genetic Information
 Discharge Summary Drug/Alcohol Treatment HIV/AIDS
 Operative Report Radiology Reports Billing _____
 History & Physical Laboratory Reports Other: _____
 Clinic/Progress Notes Other Test Results
 Immunization Records

INFORMATION TO BE USED FOR:

Continuity of Medical Care Damage/Claim Information Personal Other: _____

Authorization for the use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Colorado Mountain Medical, PC may not use or disclosure your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation form and returning the form to this office.

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above; I understand that once this information is disclosed, it may no long be protected by Colorado Mountain Medical. I understand that this authorization is voluntary, that further treatment can not be conditioned upon signing this authorization and that there may be a cost to copy records.

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 190 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

Signature of Patient or Authorized Representative

Date of Signature

Printed Name

Relationship to Patient (if applicable)