HIPAA AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

_____ Written Records _____ _____Verbal Patient Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
_____
_____

Release To: _____ Release From: _____
Address: _____ Address: _____
_____ _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s).

1) Drug Abuse/Alcohol Abuse (Fed. Reg. 42 C.F. R., Part 2)
2) Psychological or psychiatric conditions
3) A test for the presence of antibodies (HIV/virus which causes AIDS
4) An AIDS diagnosis and/or an AIDS related condition
5) Any third party source (hospital, specialist office, lab)

**According to Colorado Statutes (GCCR 1101-1, Rule XIV), there is a charge for copies of medical records. The charge is $14.00 for the first 10 pages, $.50/pages 11-39, and $.33/page for pages 40 and above. We require $14.00 up front to begin copying information.

Information Requested (Please mark the box for all items you authorize to be released):

_____ Doctor's notes _____ X-Ray reports _____ Problem list _____ Medication list
_____ Pathology reports _____ Diagnosis studies _____ List of allergies
_____ AIDS/HIV information _____ Immunization record _____ Drug abuse/alcohol abuse
_____ Psychological/psychiatric evaluations

_____ Laboratory results From Date _____ To Date _____
_____ X-ray and imaging reports From Date _____ To Date _____
_____ Consultation reports From Date _____ To Date _____

Treatment Date(s): _____
_____
Purpose of release: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present any written revocation to the Office Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
I certify that this request has been made voluntarily. This authorization is subject to written revocation anytime, except to the extent that action has already been taken in comply with it.
In any event, this authorization expires ninety (90) days from the date of signature. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information contained in my medical records. I understand any disclosure of information comes with it the potential for an unauthorized re disclosure and the information may not be protected by federal confidentiality rules

Signature of Legal Guardian/Executor _____ Date _____

Witness _____ Signature of Patient _____

**If patient is unable to sign, please document reason: _____

INFORMATION REQUESTED WILL NOT BE PROVIDED IF ANY OF THE ABOVE ITEMS HAVE NOT BEEN COMPLETED