3555 N Lutheran Pkwy, Ste 210
Wheat Ridge, CO 80033
303-422-6043 (P)
303-422-0551 (F)
tmfa.co

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name:_____ DOB:_____

Release Medical Records FROM:

_____
Doctor/Hospital/Facility

_____
Street Address/City/State/Zip Code

_____
Phone Number/Fax Number

Send Medical Records TO:

_____
Doctor/Hospital/Agency/Facility/Person

_____
Street Address/City/State/Zip Code

_____
Phone Number/Fax Number/Email

RECORDS TO BE DISTRIBUTED BY:

___ Fax

___ Pick Up

*** 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 Release ___ N/A

INFORMATION TO BE RELEASED (check all that apply:

Date of Service range (month/year) From:_____ To:_____

__ Emergency Room Report
__ Discharge Summary
__ Operative Report
__ History & Physical
__ Clinical/Progress Notes
__ Mental Health Treatment
__ Drug/Alcohol Treatment
__ Radiology Reports
__ Laboratory Reports
__ Immunization Records
__ Genetic Information
__ HIV/AIDS
__ Billing:_____
__ Other:_____
__ Other Test Results

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 disclose 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 use and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation form and submitting 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 longer be protected by Colorado Mountain Medical. I understand that this authorization is voluntary, that further treatment cannot 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 or facsimile of this form is to be considered valid as the original.

_____ _____
Signature of Patient or Authorized Representative — Date of Signature

_____ _____
Printed Name — Relationship to Patient (if applicable)