



3555 Lutheran Pkwy. #210
Wheat Ridge, CO 80033
(303) 422-6043
Fax (303) 422-0551

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:

***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**

Fax

Pick-Up

INFORMATION TO BE RELEASED (check all that apply):

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

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 longer 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 90 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)

Anthony Valenti, DPM
Certified in Foot Surgery

Gregory Still, DPM
Certified in
Foot & Ankle Surgery