RELEASE OF MEDICAL RECORD AUTHORIZATION FORM

Name: _____ Address: _____
DOB: _____ _____

RELEASE RECORDS TO:

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

RELEASE RECORDS FROM:

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

CHECK ALL THAT APPLY

☐ X-ray Reports ☐ Progress Notes ☐ Hospital Reports ☐ Laboratory Reports
☐ DEXA Reports ☐ Medication Record ☐ Entire Record
☐ Other _____

Delivery Method:

☐ Pick-Up ☐ Call once records are ready for Pick-up ☐ Mail records ☐ Fax _____

☐ I authorize _____ to pick up my medical records
Name

I authorize the above facility to release the information ☐ ecified only to the written named organization or physician listed. I understand that the information to b ☐ leased may include sensitive information regarding specific conditions or diagnoses.

In compliance with Colorado Statute charges and fees will be applied for the release of medical information .I will pay a fee of $14.00 for the first 10 pages, $.50 per page for 11-40, and $.33 for every additional page. Additional postage and shipping charges may also apply.

_____ _____
Patient's Signature Date of Release

If the patient is a minor, deceased or subject to legal guardianship and you have consent to sign on the patients behalf:

_____ _____
Legal Guardian's Signature Legal Guardian's Printed Name

Medical Practice(s): Information obtained through medical practices is privileged and confidential. Medical records should not be disclosed to person(s) without a separate written authorization from the patient.