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 specified only to the written named organization or physician listed. I understand that the information to be released 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.