

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION



NAME: _____

Date of Birth: _____

Phone #: _____

RELEASE TO: _____

Address: _____

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/ alcohol abuse(Federal Regulation 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

AT NO COST TO YOU WE WILL PROVIDE COPIES OF GROWTH CHART, MEDICATIONS PRESCRIBED, SHOT RECORD, LAST PHYSICAL EXAM, AND LAST SICK VISIT.

While in our practice, did your child have any chronic conditions, ongoing disease process or serious injuries? [] no [] yes

If yes, please state _____

Reason for Records Release

- [] Consult with Specialist
[] Legal or insurance matters Treatment dates needed _____
[] Leaving Practice
[] Moving out of Area
[] Change of Insurance
[] Other _____

READ BEFORE SIGNING- If more than a brief summary is required the following may apply: I do acknowledge that in accordance with the State of Colorado Statute there is a charge for copies of medical records. The charge is \$16.50 for pages 1-10, \$0.75 per page for pages 11-40, and \$0.50 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any, may also be charged.

I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to 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.

Date

Signature of Patient (if 18 and older)

Witness

Signature of Legal Guardian/ Parent