# AUTHORIZATION TO RELEASE HEALTH INFORMATION

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I hereby authorize the following to release my health information for the purpose of continuing health care:

Patient Name: _____ DOB: _____ Phone: _____

**Party Releasing Medical Records:** _____

Phone: _____ Fax: _____

**SEND RECORDS TO:** _____

Phone: _____ Fax: _____

**RECORDS TO BE RELEASED:**

Dates of service: _____ to _____

[ ] Office notes/history & physical exams
[ ] Radiology reports and bone density exams
[ ] Labs
[ ] Hospital reports & discharge summaries
[ ] Medication records
[ ] Entire record
[ ] Other: _____

**If you would like any of the following sensitive information disclosed, check the applicable box(s) below:**

[ ] Alcohol/Drug Abuse Treatment/Referral [ ] HIV/AIDS-related Treatment
[ ] Sexually Transmitted Diseases [ ] Mental Health (Other than Psychotherapy Notes)
[ ] Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege

I understand that the medical information released by this authorization may include treatment of physical and mental illness, alcohol/drug abuse, and past medical history.
I understand that this authorization may be revoked in writing at any time. If it is revoked, it will not affect any actions already taken based upon this authorization. I also understand that revocation will not apply to information that has already been released as specified by this authorization.

I understand that any disclosure of information carries the potential for no-disclosure and will no longer be protected by federal confidentiality rules.
I accept full financial responsibility for copying fees including shipping charges per Colorado Department of Public Health and Environment Regulations. The fees are as follows:

- $18.53 for the first 10 pages
- $0.85 per page for the next 30 pages
- $0.57 per page for each additional page
- $10 fee if the authorized person requests certification of the medical records
- Actual postage and electronic media costs where applicable

No fees are charged for records sent to another health care provider.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date