

AUTHORIZATION TO RELEASE HEALTH INFORMATION

MOUNTAIN RHEUMATOLOGY, LLC

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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:

Date of service: _____ to _____ **The past year** **The past 3 years**

- | | |
|--|---|
| <input type="checkbox"/> Office Notes/History & Physical Exams | <input type="checkbox"/> Hospital Reports & Discharge Summaries |
| <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Bone Density Exams | <input type="checkbox"/> Entire Medical Record |
| <input type="checkbox"/> Labs | |
| <input type="checkbox"/> Other: _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> Alcohol/Drug Abuse Treatment/Referral | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> HIV/AIDS-related Treatment | <input type="checkbox"/> Mental Health (Other than Psychotherapy Notes) |
| <input type="checkbox"/> 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 of Patient

Date