AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

This release expires 90 days from the date of signature or upon written notification.

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Previous name under which records may be filed: _____

Patient's Phone Number: _____

Patient's Address: _____

I specifically authorize any current employee of the Dynamic Healthcare Team to release my Medical Records as described on this form to the recipient listed below. I understand that when the information is released it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI).

Purpose(s) of the information to be released: _____

Please release my Medical Records to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Release These Records:

____ 1. **ALL** medical records at this facility.

____ 2. Only records **GENERATED** by this facility (not from other sources).

____ 3. Only some portions of records maintained at facility (specify below).

Patient Signature: _____ Date: _____
(Or legally authorized representative with description of authority)
Relationship to Patient if legal representative: _____

This release includes these specific records (initial each individually):

____Drug Abuse If Any

____ Psychological or Psychiatric Conditions If Any

____Substance Abuse If Any

____AIDS/HIV If Any

- **As required by the Health Insurance Portability and Accountability Act of 1996 Dr. Ripley R. Hollister, MD may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.**

If you are authorizing this office to send your records to another physician because you are changing Primary Care Providers, please check the reason for your decision:

____I'm moving.
____I'm changing insurance providers.
____I am dissatisfied with the service at this facility.
____I am dissatisfied with the location of this facility.

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This release expires 90 days from the date of signature or upon written notification.

Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Previous name under which records may be filed: _____

Patient's Phone Number: _____

Patient's Address: _____

I specifically authorize any current employee of: Physician's office: _____
Address: _____
Phone and fax # _____

to release my Medical Records as described on this form to the recipient listed below. I understand that when the information is released it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI).

Purpose(s) of the information to be released: _____

Please release my Medical Records to:

Dynamic Healthcare Team
2855 Dublin Boulevard
Colorado Springs, CO 80918-1662

Release These Records:

____ 1. **ALL** medical records at this facility.

____ 2. Only records **GENERATED** by this facility (not from other sources).

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____I'm moving.
____I'm changing insurance providers.
____I am dissatisfied with the service at this facility.
____I am dissatisfied with the location of this facility.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Dr. Ripley Hollister. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire _____.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____

Signature Date

Revocation Section

I hereby revoke this authorization.

_____ _____

Signature Date

If changing physicians, please state why for informational purposes.

_____

_____

_____

_____

_____