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Conifer, CO 80433

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|------------------|
| For internal use |
| Date Sent _____ |

Release of Patient Information

_____ **Release of Written Records**

_____ **Release of Verbal Patient Medical Information**

Patient Name: _____

Patient Date of Birth: _____

Address: _____

Phone #: _____

Email: _____

Release to: _____

Phone _____

Address: _____

FAX: _____

Contact _____

Release from: _____

Phone: _____

Address: _____

FAX: _____

I request and authorize the release of information to the above named recipient. I understand that the information may include the following: Drug or alcohol abuse/Psychological or psychiatric conditions/ HIV (AIDS) testing/AIDS diagnosis/records from 3rd party source such as a hospital, lab or specialist.

According to Colorado Statute (GCCR 1101-1, Rule XIV), there may be a charge for copies of medical records. The releasing party may charge \$14.00 for the first 10 pages, \$.50/page for pages 11-39 and \$.33/page for pages 40 +.

Purpose of release: _____

I request the abbreviated version of the chart: Problem list, Growth charts, Immunization records.

I request the entire chart. (Please mark ONLY if the doctor requests the entire chart.)

Specific Date(s): (if applicable) _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present written revocation to the releasing office. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition _____. I certify that this request has been made voluntarily. This authorization expires 90 days from the date of signature. I release the above named from liability pertaining to the disclosure of requested information. I understand any disclosure carries with it the potential for an unauthorized and federally unprotected re-disclosure.

Signature of Legal Guardian: _____ **Date** _____

(if patient is a minor)

Guardian is (please check one): Mother _____ Father _____ Foster parent _____ Other _____

Signature of patient: _____ **Date** _____

(if patient is a legal adult)