

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Patient Name: _____ Chart Number: _____
Date of Birth: _____ Phone Number: _____

Obtain From: (Releasing Facility) Release To: (Receiving Entity)

_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip	_____ City State Zip
_____ Phone Fax	_____ Phone Fax

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by Boulder Medical Center, P.C. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

Date of service range (month/year): From: _____ To: _____

<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Mental Health Treatment	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Drug/Alcohol Treatment	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> X-Ray Films maintained by Radiology Dept
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Laboratory Reports	Other: _____
<input type="checkbox"/> Clinic/Progress Notes	<input type="checkbox"/> Other Test Results	_____
<input type="checkbox"/> Immunization Records		

INFORMATION IS TO BE USED FOR:

Continuity of Medical Care Damage/Claim Information Personal Use

Other: _____

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy or facsimile of this form is to be considered as valid as the original.

Signature of Patient or legally authorized Representative Date of signature

Printed Name if signed on behalf of the patient Relationship to patient, if applicable

PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS

I hereby acknowledge that I, the patient/authorized representative, have inspected _____ and/or received _____ photocopies of the medical records from the _____ for the above named patient.

Date Signature Date Witness signature

BOULDER MEDICAL CENTER, P.C.
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Confidential and Proprietary Information
FORM AUTH001a - Rev 04172006