Authorization To Disclose Health Information

Physician or facility to provide records: _____

Address: _____

_____

Phone #: _____

Patient's Name _____

Social Security #: _____ DOB: _____

I authorize the information to be disclosed to and used by the following individual or organization:

Rocky Mountain Family Practice , 205 S. Main ST. #B, Longmont CO 80501
Phone: 303-772-6244, Fax: 303-702-1623

For the purpose of _____

The type and amount of information to be disclosed is as follows: (specify dates where appropriate)

( ) Entire medical record
( ) Immunizations
( ) Laboratory results from date _____ to date _____
HIV/AIDS information from date _____ to date _____
( ) Most recent 3 years of record
( ) X-ray reports from date _____ to date _____

Other _____

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Rocky Mountain Family Practice cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents is $14.00 for the first ten pages, $.50 per page for pages 11 through 40 and $.33 per page for each page over 40. Shipping and applicable sales tax will also be charged. There is no charge for records sent to another health care provider.

Patient or Authorized Personal Representative Signature _____ Date _____

Personal Representative's Name (print) and Relationship
(Please attach applicable legal documentation of authority) _____ Date _____