Aspen Creek Family Medicine
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HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

****Please print all information**

Patient name:_____ Date of birth:_____

Social security number: Phone: _____ ( ) H ( ) W ( ) C

Release records TO: _____ Release records FROM: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Purpose of release: _____

I request and authorize the release of information to the organization, agency or individual named above. I understand that the information to be released may include the following conditions:

1. Drug/alcohol abuse (Red. Reg. 42 C.F.R. Part 2)
2. Psychological or psychiatric conditions
3. Test for the presence of HIV antibodies/virus which causes AIDS
4. AIDS diagnosis and/or an AIDS condition
5. Any third party source (hospital, labs, spec)

***According to the Colorado State Statute (GCCR 1101-1, Rule XIV), there is a charge for copies of medical records. The charge is $14.00 for the first 10 pages, $0.50per page for pages 11-39 and $0.33 per page for pages 40 and above.

Information requested:

___ Entire record
___ Doctor's notes
___ Pathology reports
___ AIDS/HIV information
___ Psychological/psychiatric evaluations
___ Most recent history & physical
___ Laboratory results: ( ) All or ( ) Specify date(s): _____
___ X-ray & imaging reports: ( ) All or ( ) Specify date(s): _____
___ Consultation reports: ( ) All or ( ) Specify date(s): _____
___ All records in specified date range: _____
___ X-ray reports
___ Diagnostic studies
___ Immunization records
___ Problem list
___ Other: _____
___ Third party records
___ List of allergies
___ Drug/alcohol abuse
___ Medication list

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 my written revocation to the site Practice Manager. 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 is subject to written revocation at any time, expect to the extent that the action has already been taken to comply with it.

In any event, this authorization expires ninety (90) days from the date of signature. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand 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.

_____ Date
Patient Signature

_____ _____
Witness Signature Date

If patient is unable to sign, please document the reason: _____