Smoky Hill Family Medicine

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Centennial, CO 80112

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HIPAA Authorization Release for Medical Records

Patient Name (Print):Patient Phone Number:	Date of Birth:	
Release To: (Facility/Provider Name):	Release Fro	om: (Facility/Provider Name):
Address	Address	
AddressPhone/Fax #	Phone/Fax	#
 released MAY INCLUDE the following co Drug Abuse/Alcohol Abuse (fed. Reg. Psychological or psychiatric conditions A test for the presence of antibodies (H An AIDS diagnosis and/or an AIDS rel Any third party source (hospital, special) 	ndition(s). 42 C.F.R. Part 2) (IV/virus) which cause AIDS ated condition alists, labs)	named above. I understand that the information to be ow the items you authorize to be released):
• • •	entire record or <u>SPECIFY</u> belo	ow the items you authorize to be released):
ENTIRE RECORD	D: 4: 04 1:	
Doctors' Notes	Diagnostic Studies	Pathology Reports
Immunization Records	AIDS/HIV Information	List of Allergies
Psychological/Psychiatric Evaluation	Drug Abuse/Alcohol Abuse	Laboratory Results
Problem List	X-Ray/Imaging Results Medication List Otl	
Consultation Reports Treatment Dates		ner
Purpose of Release:		
present my written revocation to the Privacy Of response to this authorization. I understand the the rights to contest a claim under my policy. U	ficer. I understand the revocation will revocation will NOT apply to my ins nless otherwise revoked, this authori	I revoke this information, I must do so in writing and I not apply to information that has already been released in urance company when the law provides my insurer with zation will expire one year from this request. I certify that a revocation at any time except to the extent that action has
requested documents is \$18.53 for the first ten p is a \$10.00 fee to all patients requesting a person	pages, \$0.85 per pages for page 11 th nal copy of medical records. I release ation contained in my medical record	ublic Health Environment Regulations, the fee for copying rough 40, and \$0.57 per page for each page over 40. There is the above named from liability and claims of any nature its. I understand any disclosure of information carries with its day federal confidentiality rules.
Signature of patient or authorized personal	representative Date	
Personal representatives name (printed) and	l relationship	