Smoky Hill Family Medicine
13111 East Briarwood Avenue, Suite 215
Centennial, CO 80112
Phone: 303-680-9150 Fax: 303-680-9149

HIPAA Authorization Release for Medical Records

Patient Name (Print):_____ Date of Birth:_____
Patient Phone Number:_____

Release To: (Facility/Provider Name):
_____
Address_____
Phone/Fax #_____

Release From: (Facility/Provider Name):
_____
Address_____
Phone/Fax #_____

I request and authorize the release to the organization, agency, or individual named above. I understand that the information to be released MAY INCLUDE the following condition(s).

- Drug Abuse/Alcohol Abuse (fed. Reg. 42 C.F.R. Part 2)
- Psychological or psychiatric conditions
- A test for the presence of antibodies (HIV/virus) which cause AIDS
- An AIDS diagnosis and/or an AIDS related condition
- Any third party source (hospital, specialists, labs)

Information Requested (please <u>CIRCLE</u> entire record or <u>SPECIFY</u> below the items you authorize to be released):

ENTIRE RECORD

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	
Consultation Reports	Medication List	Other _____
Treatment Dates _____		

Purpose of Release:_____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this information, I must do so in writing and present my written revocation to the Privacy Officer. 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 rights to contest a claim under my policy. Unless otherwise revoked, this authorization will expire one year from this request. I certify that this request has been made VOLUNTARILY. This authorization is subject to written revocation at any time except to the extent that action has already been taken to comply with it.

I accept full financial responsibility for copying fees. Per Colorado Department of Public Health Environment Regulations, the fee for copying requested documents is $18.53 for the first ten pages, $0.85 per pages for page 11 through 40, and $0.57 per page for each page over 40. There is a $10.00 fee to all patients requesting a personal copy of medical records. 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. The information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient or authorized personal representative Date

_____
Personal representatives name (printed) and relationship