Denver Arthritis Clinic

MEDICAL RECORDS DEPARTMENT
303-394-2828 *phone* ■ 303-320-0242 *fax*

RELEASE OF MEDICAL RECORD AUTHORIZATION FORM

Note to Recipient of Records: The patient's medical record is privileged information which is protected by various State and Federal laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

PATIENT INFORMATION:

Name: _____
Address: _____
_____
DOB: _____
Phone #: _____

RELEASE TO:

Name: _____
Address: _____
_____
_____
_____

RELEASE FROM: _____

Name: _____
Address: _____
_____
Phone: _____ Fax: _____

Authorize Denver Arthritis Clinic to release to the party listed below the following information from my medical records:

(Check and/or circle appropriate items)

☐ Complete Record
☐ History and Physical Report
☐ Medication Record
☐ Recommendations/Physician Orders
☐ Other _____
☐ X-Ray reports
☐ Surgical/Procedure Reports
☐ Laboratory Reports
☐ X-Rays

I request and authorize the above-named health care provider to release the information specified above to the organization or individual named on this request. I understand that the information to be released may include information regarding the following condition(s): Sickle Cell Anemia; Genetic testing; Human Immunodeficiency Virus (HIV); Drug Abuse; Alcoholism; Alcohol Abuse, if any; Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any.

I understand that:

1. My signature on this form is strictly voluntary.
2. I may revoke this authorization any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations.
4. Fees/charges will comply with all faxes and regulations applicable to release of information.
   I understand that in compliance with Colorado Statute, I will pay a fee of $14.00 for the first 10 pages, $.50 per page for 11-40 pages, and $.33 for every additional page. Actual postage or shipping costs may also be charged.

_____ _____
(Patient's Signature) (Date)

If the patient is a minor, subject to a guardianship or is deceased, I have signed my name below on behalf of the patient and myself:

_____ _____
(Patients', Legal Guardian's or Agent's Signature) (Date)

I witnessed the signature on this form: Name of Witness: (Please Print) _____

_____ _____
(Witness's Signature) (Date)

_____ _____
(Patients', Legal Guardian's or Agent's Signature) (Date)

Delivery Instructions

☐ Call requestor for pick-up when records are ready
☐ Mail records directly to the person or organization specified.
☐ I authorize _____(name) to pick up my Protected Health Information (PIH)
Relationship:_____