Colorado Mountain Medical
Doctors you know and trust

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PO Box 4330
Avon, CO 81620
Phone (970) 926-6340
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AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION

PATIENT INFORMATION:

Patient Name: _____ Date of Birth: _____

Release Medical Records FROM:

_____
Doctor / Hospital / Facility

_____
Street Address / City / State / Zip Code

_____
Phone Number / Fax Number

Send Medical Records TO:

_____
Doctor / Hospital / Agency / Facility / Person

_____
Street Address / City / State / Zip Code

_____
Phone Number / Fax Number / Email

RECORDS TO BE DISTRIBUTED BY:

____ Fax
____Mail (___Paper Copy ___Encrypted CD)
____Encrypted Email
____Pick-Up (___Edwards ___ Vail____ Eagle)

***I understand that my medical records may contain information concerning my mental health and/ or psychiatric treatment, drug and/or alcohol treatment as well as any HIV test results (AIDS). ___** Authorize Release ___ Do **NOT** Authorize ___ Not applicable

INFORMATION TO BE RELEASED (check all that apply):

Date of Service range (month/year): From: _____ To:_____

___Emergency Room Report	___Mental Health Treatment	___Genetic Information
___Discharge Summary	___Drug/Alcohol Treatment	___HIV/AIDS
___Operative Report	___Radiology Reports	___Billing _____
___History & Physical	___Laboratory Reports	___Other:_____
___Clinic/Progress Notes	___Other Test Results	_____
___Immunization Records		

INFORMATION TO BE USED FOR:

____Continuity of Medical Care ____Damage/Claim Information ____Personal Other:_____

Authorization for the use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Colorado Mountain Medical, PC may not use or disclosure your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation form and returning the form to this office.

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above; I understand that once this information is disclosed, it may no long be protected by Colorado Mountain Medical. I understand that this authorization is voluntary, that further treatment can not be conditioned upon signing this authorization and that there may be a cost to copy records.

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 190 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

_____ _____
Signature of Patient or Authorized Representative **Date of Signature**

_____ _____
Printed Name **Relationship to Patient (if applicable)**