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AUTHORIZATION FOR THE RELEASE OF PATIENT PROTECTED HEALTH INFORMATION TO A THIRD PARTY

PATIENT INFORMATION:

Patient Name: Date of Birth:

I authorize Colorado Mountain Medical to disclose my protected health information* to

Relationship to patient:

For the purpose of:

Continuity of Medical Care Damage/Claim Information Personal Other:

*I understand that my medical records/protected health information 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 Release Not applicable

INFORMATION TO BE RELEASED (check all that apply):

I authorize the above named individual(s) or facility to verbally speak with Colorado Mountain Medical regarding my protected health information (PHI), and have access to, ALL information contained in my PHI record.

OR

I authorize the above named individual(s) or facility to verbally speak with Colorado Mountain Medical regarding my protected health information (PHI), and have access to, only the following information contained in my PHI record that I have checked below:

- 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

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 disclose 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 a separate 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 longer 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)