



303-328-3400 phone ■ 303-328-3401 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:

Authorize Northwest Regional Ambulatory Surgery Center to release to the party listed above the following information from my medical records: (Check and/or circle appropriate items)

- Complete Record
History and Physical Report
Medication Record
Admission & Financial Records
Laboratory Reports
Other
X-Ray reports
X-Rays
Surgical/Procedure Reports
Anesthesia Records

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 taxes and regulations applicable to release of information.

I understand that in compliance with Colorado Statute, I will pay a fee of \$16.50 for the first 10 pages, \$.75 per page for 11-40 pages, and \$.50 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)

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: