**Medical Records Release Form**

I hereby authorize the use or disclosure of health information from the medical record of:

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Best Contact telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize **FROC, P.C.** to release confidential health information about me, by releasing a

copy of my medical records, a summary or narrative of my protected health information, or

verbally to the individual or organization listed below.

**Specific Description of the Information to be released:**

\_\_ Progress Notes \_\_ Radiology films

\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Diagnostic study reports (labs, radiology, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Outside records (hospital, therapy, other doctors)

I understand that the information in my health record may include information relating to

sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human

immunodeficiency virus (HIV). It may also include information about behavioral or mental

health services, and treatment for alcohol and drug abuse.

\_\_ **Yes**, I consent to the release of this information.

\_\_ **No**, I do not consent to the release of this information.

**This information may be disclosed to and used by the following individual or**

**organization:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The reasons or purposes for this release of information are as follows:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information released is for the specific purpose stated above. Any

other use of this information without the written consent of the patient is prohibited.

However, I understand that any disclosure of information carries with it the potential for an

unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I understand that I may revoke this authorization at any time by notifying FROC, P.C. in

writing. I understand that the revocation will not apply to information already released in

response to this authorization. I understand that the revocation will not apply to my

insurance company when the law provides my insurer with the right to contest a claim

under my policy.

I understand I may be charged a reasonable fee in accordance with regulations governed by

the Colorado Department of Public Health & Environment.

**Unless otherwise revoked, this authorization will expire on the following date, event or**

**condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I fail to specify an expiration date,**

**event or condition, this authorization will expire in one year.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient or Legal Representative Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (If Legal Representative)

**Office Use Only:**

Chart#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Request received: \_\_\_\_\_\_\_\_

Request completed:\_\_\_\_\_\_\_\_

Initials: \_\_\_\_\_\_\_\_\_\_\_\_

Charges $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pymt received: \_\_\_\_\_\_\_\_\_\_\_