Pinon Family Practice

Authorization For Release of Medical Records

Patient Name:	Date of Birth:
Address:	Phone(s):

*This Authorization applies to all of the following information:

**Please select one++

[______] **All Information**; I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

[______] **Only** the following records or types of Information:

[___] Office Visits [___] Labs [___] Radiology [___] ETOH/substance abuse

[___] Mental Health record [___] HIV/STD records [___] EKG, Spirometry

[___] Other (Please specify) ______________________________

[______] ***Release all of the above approved records or, only for the following treatment dates: __________ to __________**

*Disclose information **FROM**: (Facility Name and Address)	***Phone:**	***Fax:**
Disclose information TO: **Pinon Family Practice** **9895 West Remington Place** **Littleton Colorado 80128**	**Phone:** **303-948-2676**	**Fax:** **303-904-9151**

***Purpose of release: [___] Change in Primary Care Provider [___] Other (Please specify) ______________________**

*This authorization ends on: [_______________] (date) *If no date is specified, this authorization will end after 180 days from date of signature.*

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Pinon Family Practice.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Pinon Family Practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

I agree that a photocopy or digital image of this agreement shall be as valid as the original.

If under 18 years of age, you must have a parent or guardian sign below.

***Signature of Patient, Guarantor or Agent:**	**Date:**

If the above named patient is over 18 and is not able to acknowledge the above consents and notices, court documentation (e.g., POA) must be provided. Please print the name/relationship of the "Agent" below.

Agent/Guarantor:____Title/Relationship:_________________________