Medical Records Release

Colorado Eye Surgeons

3401 Quebec Street, Suite 4100
Denver, CO 80207
Phone #: (720) 844-6100 Fax #: (720) 844-6101

_____ _____
(Name of Patient) (Birthdate)

_____ _____
(Street Address) (City, State, Zip Code)

Authorizes:

_____
(Name of Physician or Health Care Facility)

_____
(Street Address)

_____
(City, State, Zip Code)

Release of Records to:

_____
(Name of Physician or Health Care Facility)

_____
(Street Address)

_____
(City, State, Zip Code)

Information to be released:

[ ] All Clinic Records [ ] Office [ ] Photographs [ ] Visual Fields [ ] Other (Specify)

List other facilities' records to be included when releasing for the purpose of continuing medical care:

_____

For the following dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

[ ] Mental Health [ ] AIDS-related disease [] AIDS test results [ ] Developmental Disability

[ ] Drug Abuse diagnosis [ ] Alcoholism [ ] Other (specify)

Purpose or need for disclosure: (Check all applicable)

[ ] Further Medical Care [ ] Vocational rehabilitation [ ] Legal Investigation

[ ] Application for Insurance [ ] Evaluation [ ] Other (specify)

[ ] Disability Determination [ ] Personal

I understand that this authorization is valid for one (1) year unless otherwise state below or revoked through written notice to the Privacy Officer of the Practice. _____
(Alternate date if not one year)

Please note, HIPAA does not allow this organization to condition treatment, payment, enrollment, or eligibility for benefits upon receiving this authorization. The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this for you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization.

Signature of Patient: _____ **Date:** _____
(If signed by person other than patient, state relationship and authorization to do so)

_____ _____
(Authorized signature) (Relationship)

Patient is: [ ] Minor [ ] Incompetent [ ] Disabled [ ] Deceased

Legal Authority: [ ] Legal [ ] Legal Guardian [ ] Next of kin of deceased