

# AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Obtain From: (Releasing Facility) Release To: (Receiving Entity)

_____ Name			_____ Name		
_____ Address			_____ Address		
_____ City	_____ State	_____ Zip	_____ City	_____ State	_____ Zip
_____ Phone		_____ Fax	_____ Phone		_____ Fax

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by Boulder Medical Center, P.C. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

## INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

Date of service range (month/year): From: \_\_\_\_\_ To: \_\_\_\_\_

<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Mental Health Treatment	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Drug/Alcohol Treatment	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> X-Ray Films maintained by Radiology Dept
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Laboratory Reports	Other: _____
<input type="checkbox"/> Clinic/Progress Notes	<input type="checkbox"/> Other Test Results	_____
<input type="checkbox"/> Immunization Records		

## INFORMATION IS TO BE USED FOR:

Continuity of Medical Care       Damage/Claim Information       Personal Use

Other: \_\_\_\_\_

**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 180 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 or facsimile of this form is to be considered as valid as the original.

\_\_\_\_\_  
Signature of Patient or legally authorized Representative      \_\_\_\_\_  
Date of signature

\_\_\_\_\_  
Printed Name if signed on behalf of the patient      \_\_\_\_\_  
Relationship to patient, if applicable

## PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS

I hereby acknowledge that I, the patient/authorized representative, have inspected \_\_\_\_\_ and/or received \_\_\_\_\_ photocopies of the medical records from the \_\_\_\_\_ for the above named patient.

\_\_\_\_\_  
Date      \_\_\_\_\_  
Signature      \_\_\_\_\_  
Date      \_\_\_\_\_  
Witness signature

**BOULDER MEDICAL CENTER, P.C.**  
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Confidential and Proprietary Information  
FORM AUTH001a - Rev 04172006