



AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION
PLEASE DO NOT FAX IF OVER 20 PAGES- PLEASE MAIL

PATIENT INFORMATION	Patient Name _____		Date of Birth _____	MR # _____	
	Address _____		Phone Number _____		
	City _____	State _____	Zip Code _____		
	Electronic Request: _____ E-Mail _____ CD _____		Paper Request: _____		
	Email Address for Record Delivery				
<p>_____ 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.</p>					
INFORMATION REQUESTED	INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):				
Service dates _____	____ Emergency Room Report	____ Mental Health Treatment	____ Genetic Information		
From: _____	____ Discharge Summary	____ Drug/Alcohol Treatment	____ HIV/AIDS		
To: _____	____ Operative Report	____ Radiology Reports	____ X-Ray Films maintained by Radiology Dept		
	____ History and Physical	____ Laboratory Reports	Other: _____		
	____ Clinic/Progress Notes	____ Other Test Results	_____		
	____ Immunization Records				
INFORMATION IS TO BE USED FOR:	____ Continuity of Medical Care	____ Damage/Claim Information	____ Personal Use		
	Other: _____				
INFORMATION TO BE RECEIVED FROM:	Company, Person, Facility _____		Phone Number _____		
	Address _____	City _____	State _____	Zip code _____	

AUTHORIZATION: I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Boulder Medical Center Notice of Privacy Practices explains the process for revocation, which includes a request in writing. 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 _____
Date
In requesting the medical records as the designated agent, in signing below, I attest to the continuing inability of the above patient to make or communicate health care directions.

Signature of Designated Agent _____
Date

Date Received: _____

PLEASE DO NOT FAX IF OVER 20 PAGES- PLEASE MAIL
Release of Records - Telephone 303-440-3135 Fax 303-449-9380

Confidential and Proprietary Information FORM AUTH001a - Rev 09232011

Boulder Medical Center, P.C.