BOULDER MEDICAL CENTER, P.C.

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 Paper Request:_____

Email Address for Record Delivery

_____ 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 REQUESTED

Service dates

From: _____

To: _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

____ Emergency Room Report
____ Discharge Summary
____ Operative Report
____ History and Physical
____ Clinic/Progress Notes
____ Immunization Records
____ Mental Health Treatment
____ Drug/Alcohol Treatment
____ Radiology Reports
____ Laboratory Reports
____ Other Test Results
____ Genetic Information
____HIV/AIDS
____ X-Ray Films maintained by Radiology Dept
Other: _____
_____

INFORMATION IS TO BE USED FOR:

____ Continuity of Medical Care ____ Damage/Claim Information ____ Personal Use
Other: _____
_____

Obtain From (Releasing Facility)	Release to: (Receiving Facility)
Company, Person, Facility Phone Number	Company, Person, Facility Phone Number
Address City State Zip code	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: _____

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Release of Records - Telephone 303-440-3135 Fax 303-449-9380
RECORDS MUST BE MAILED TO:
BOULDER MEDICAL CENTER, P.C.
ATTN: MEDICAL RECORDS
2750 BROADWAY
BOULDER, CO 80304