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

Patient Name | Date of Birth | MR #

Address | Phone Number

City | State | Zip Code

Please allow for 10 business days for any request. Please select delivery method:
_____ All paper requests **will be** fulfilled by mail. Records can no longer be picked up at Boulder Medical Center, P.C.(BMC)
_____ For electronic delivery, please provide an email address below. Due to HIPAA regulations regarding security of electronic transmissions, we cannot email records to anyone but your personal email.

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):

Service Dates Requested: To _____/_____/_____ From _____/_____/_____

____ Clinic/Progress Notes
____ Procedure Reports
____ Immunization Records
____ Radiology Reports
____ Laboratory Reports

I am requesting my records(check one):
☐ from the Entity listed below to be mailed to _____ at BMC or faxed to _____ (Fax Number)
or
☐ to be sent to Entity listed below

Entity and Provider

Address City State Zip code

Phone Number:_____

- I hereby give the releasing entity permission to disclose my individually identifiable health information as requested.
- I understand that once this information is disclosed by BMC, it will no longer be protected by BMC.
- I understand that only records created by BMC will be transferred to other entities.
- I understand that my clinical records may contain information that I consider to be sensitive.
- I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization.
- I understand that there may be a cost to copy the records.
- 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

Telephone 303-440-3135 Fax 303-449-9380
2750 Broadway Boulder, CO 80304