COLORADO ENT & ALLERGY
Excellence. Commitment. Compassion.

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Colorado Springs, CO 80923

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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS FORM

Patient Information: I, _____, authorize Colorado ENT & Allergy to disclose the below-named individual's medical records as described below.

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Daytime Phone: _____

Date of Birth: _____ Social Security Number: _____

Disclosure to: ☐ Self
Delivery Options: ☐ Pick Up ☐ View on Site ☐ Mail to Address Above
☐ I hereby authorize: _____ to pick up my records. (Photo ID req.)
☐ Send to: _____ (Name of Health Care Provider/Plan/Other)
_____ (Address of Health Care Provider/Plan/Other)
_____ (Fax of Health Care Provider/Plan/Other)

Information to be Disclosed:
☐ All medical records (specify conditions, treatment, etc.): _____
☐ Imaging records: _____
☐ All billing records (specify conditions, treatment, etc.): _____
☐ Allergy testing/treatment records: _____
☐ Specific records/information as follows: _____
_____
_____

I do not want the following information disclosed (as defined applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health Conditions

Expiration: This Authorization is good until the following date: _____.
(Note: If this is left blank, the authorization will expire in twelve (12) months from the date signed.

Purpose: ☐ Further Medical Care ☐ Legal Investigation/Action ☐ Insurance Eligibility/Benefits
☐ Personal (at my request) ☐ Other: _____

Your Rights with Respect to this Authorization: I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to Colorado ENT & Allergy, Medical Records Department, 3030 N. Circle Dr., Ste. 300, Colorado Springs, CO 80909. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date, this authorization will expire in twelve (12) months from the date this form is signed. I understand that authorizing the disclosure of these medical records is voluntary. I do not need to sign this form in order to receive treatment. I understand that I may be charged a fee for record copies. The copy fee is as follows: Request from Patient or Patient's Healthcare Personal Representative - $6.50; Request NOT from Patient or Patient's Healthcare Personal Representative - $14.00 (pages 1-10), $.50 per page (pages 11-40), $.33 per page (pages 41+). I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy regulations.

Signature of Patient/Legal Representative: _____ Date: _____

If signed by a person other than the patient, complete the following:
Patient is: ☐ a Minor ☐ Legally Incompetent or Incapacitated ☐ Deceased
Legal Representative is: ☐ Parent ☐ Legal Guardian
☐ Next of Kin/Executor of Deceased
☐ Medical Power of Attorney for Health Care

FOR OFFICE USE ONLY
Signature/ID verified by: _____ Date: _____