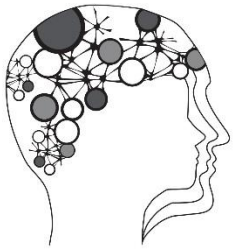
FORT COLLINS NEUROLOGY, PC
MICHAEL P. CURIEL, M.D.
medrecords@ftcollinsneurology.com



2121 E. Harmony Rd., Ste. 270
Fort Collins, CO 80528-3402
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AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

PATIENT:_____

DOB:_____

DATE OF REQUEST:_____

PHYSICIAN: _____***Timothy J. Allen, M.D.***

_____***Michael P. Curiel, M.D.***

☐ **Transfer**. Transfer records to another physician.

Transfer Records To:_____

Address:_____

_____

Phone:_____Fax:_____

☐ **Personal Copies**. Fee will apply.

☐ Mail copies to me at:_____

_____

☐ Send copies via unsecured email at:

_____

I understand that unsecured email is just that – unsecured – and that an unauthorized person may be able to intercept and access my personal information which is contained in the emailed records. By selecting this choice I am agreeing to assume that risk which is further detailed below.

- The email may be stored by the Internet Service Providers who provide transport of electronic mail
- Your email service provider has access to your stored emails depending upon their operational processes and your agreement with them
- A hacker or other unauthorized individual could use technical means to access the email during transit or on your systems once it is received
- Our office might inadvertently select the wrong recipient when sending the email
- Once the email is received at your end it may become vulnerable to unauthorized exposure via hacking, loss or theft from the various electronic workstations for devices such as smart phones that you used to access email.

FEES:

There will be a charge for personal copies of your medical records. The fee schedule is as follows: $18.53 for ten (10) or fewer pages, $.85 per page for 11-40, $0.57 per page after 40 pages.

The fee for copies of solely Payment/Billing history will be charged a flat rate of $10.00 per request.

I authorize Fort Collins Neurology, PC to release or request my medical records as requested above. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. To revoke this authorization, I may fill out a revocation form (available from this office) or I may put my request in writing and submit to Fort Collins Neurology, PC.

This authorization will automatically expire in one year unless stated otherwise

Signed: _____ **Date:** _____**Print Name:** _____

If not signed by the patient, please indicate relationship: _____