Doctors Express
Urgent Care | Family Care

760 S. Colorado Blvd., Suite A
Denver, CO 80246
Phone: (303)-692-8000
Fax: (303)-300-6685

Medical Records Release Form

(HIPAA Compliant Authorization to Use or Disclose Protected Health Information)

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

City: _____

State: _____ Zip Code: _____

Home Phone Number: _____

Other Contact Number: _____

FACILITY WHERE ORIGINAL PATIENT MEDICAL RECORDS ARE CURRENTLY STORED

Name of Facility: _____ Phone Number: _____

Address: _____ Fax Number: _____

City: _____

State: _____ Zip Code: _____

FACILITY TO SEND A COPY OF THE PATIENT MEDICAL RECORDS TO

Name of Facility: __Doctors Express Cherry Creek_____

Address: _S.Colorado Blvd., STE A _____ Fax Number: ___303-300-6685 _____

City: ____Denver_____

State: ___CO_____ Zip Code: __80246____

SELECT INFORMATION TO DISCLOSE

- ☐ Patient's entire medical record, **or**
- ☐ Facility to disclose **ONLY** the following medical record contents:
- ☐ Physician patient visit notes
- Laboratory results ☐ All, or ☐ from date: _____
- ☐ X-Ray or advanced imaging results
- ☐ Cardiac studies
- ☐ Medication notes
- ☐ Other: _____

REASON FOR REQUEST (check all that apply)

- ☐ Transferring records to another physician
- ☐ Health Insurance company changes
- ☐ Copy for personal records
- ☐ Legal
- ☐ Auto accident
- ☐ Specialist physician referral
- ☐ Other Reason: _____

AUTHORIZATION OF PATIENT (or Legal Representative)

I *authorize*----------(*facility of original medical records*) to forward a copy of the selected patient medical records to use or disclose Protected Health Information (PHI) for the purpose(s) selected above.

I *understand* the information in this health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I *understand* that I have the right to revoke this authorization at any time and if I revoke this authorization or have questions about any disclosure of my PHI, I must do so in writing and present my written revocation to the HIPAA Privacy Officer for the facility of the original medical records.

I *understand* that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in ninety (90) days or on the following date or event: _____

I *understand* that authorizing the disclosure of this PHI is voluntary and I need not sign this form in order to assure treatment.

I *understand* that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524

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 confidentiality rules. If I have questions about disclosures of my health information, I can contact the HIPAA Privacy Officer at the facility of origin of the medical record.

Signature of Patient (or Legal Representative): _____ Date: _____