Colorado Mountain Medical
Doctors you know and trust

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Authorization for the use of Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, Colorado Mountain Medical, PC may not use or disclosure your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosure of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning this form to this office.

AUTHORZATION FOR THE RELEASE AND/OR OBTAIN PATIENT INFORMATION

Patient Name:_____Date of Birth:_____

Obtain From (Releasing Facility)	**Release To:(Receiving entity)**
Name:	**Name:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Fax:**

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 long be protected by Colorado Mountain Medical. I understand that this authorization is voluntary, that further treatment can not be conditioned upon signing this authorization and that there may be a cost to copy records.

INFORMATION TO BE RELEASED (check all that apply):

Date of Service range (month/year): From:_____To:_____

___Emergency Room Report	___Mental Health Treatment	___Genetic Information
___Discharge Summary	___Drug/Alcohol Treatment	___HIV/AIDS
___Operative Report	___Radiology Reports	___Other_____
___History & Physical	___Laboratory Reports	___Billing_____
___Clinic/Progress Notes	___Other Test Results	_____
___Immunization Records		

INFORMATION IS TO BE USED FOR:

____Continuity of Medical Care ____Damage/Claim Information ____Personal

Other:_____

_____

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that this consent will expire 190 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 of facsimile of this form is to be considered as valid as the original.

_____ _____
Signature of Patient or Authorized Representative Date of Signature

_____ _____
Printed Name Relationship to Patient (if applicable)

PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS

I hereby acknowledge that I the patient/authorized representative have inspected_____and/or received_____photocopies of the medical records from Colorado Mountain Medical for the above named patient.

_____ _____ _____ _____
Date Signature Date Witness Signature