Pearl Family Medicine

Medical Records Release Form

Patient Name	Date of Birth	Last 4 of Social Security Number
Address	Cite, State, Zip Code	Telephone Number

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency, and patient name.

Release by:	Release to:
___ Facility ___ Address ___ Phone/Fax	

Treatment Dates: ❑ All ❑ Date(s):_____

Purpose: Continuation of Care

Pertinent Protected Health Information Allowed to be Included:

❑ Entire Medical Record ❑Radiology Reports ❑Operative Reports ❑ Discharge Summary ❑H&P/Consults ❑Labs
❑Psychiatric Records ❑Imaging Reports
❑ Verbal status of current and/or care management needs

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated Medical Records Department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be redisclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. I understand the facility will provide me with a copy of the signed authorization form.

Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless a different date is specified here: _____

Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS).

Signature: _____Date:_____

Patient, Parent, or Legal Guardian

Minor's signature is required for release of any records for treatment which the minor may authorize under Colorado Law. Relationship if other than patient: _____ ❑ Power of Attorney ❑Death Certificate