Medical Records Release Consent Form

Date: _____ /_____ /_____

PLEASE PRINT LEGIBLY!

Patient's Name: _____

(maiden name or alias)

Date of Birth: _____/_____/_____ Phone: (_____)_____-_____ SSN#: _____-_____-_____

Address: _____

Street City State Zip

The following individual or organization is authorized to make thie disclosure:

Release my records from: _____

(Your previous physician's office)

Address: _____

Street City State Zip

Phone: (_____)_____-_____ Fax Number: (_____)_____-_____

This information may be disclosed to and used by the following individual or organization:

Please Release my records to:

Partners In Health
Heather Fliege, MD
308 W. Baseline Rd.
Lafayette, CO 80026
PH: 303-554-9000
Fax: 303-543-9729

******IF MEDICAL RECORD IS MORE THAN 10 PAGES, PLEASE MAIL******

Specific information to be released includes: (Circle all that apply)

ALL RECORDS EKGs **ONLY** Immunization records **ONLY** X-Ray Reports **ONLY**

Lab Reports **ONLY** (please specify: blood, pap smears, other:_____)

Other records: (Please specify: _____)

I understand that the information in my records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral o mental health services or treatment for alcohol and drug abuse. I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules. I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to ensure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

(If I do not specify, a date/event/condition, this authorization will expire in 1 year)

Signed: _____ Date:_____/_____/_____