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# AUTHORIZATION TO DISCLOSE MEDICAL RECORDS FORM

**Patient Information:** I, ______________________________, authorize Colorado ENT & Allergy to disclose the below-named individual's medical records as described below.
Name: ______________________ Address: ______________________
City: ____________________ State: _____ Zip: __________ Daytime Phone: ____________
Date of Birth: ______________ Social Security Number: ______________________

**Disclosure to:** ☐ Self
Delivery Options: ☐ Pick Up ☐ View on Site ☐ Mail to Address Above
☐ I hereby authorize: ____________________ to pick up my records. (Photo ID req.)
☐ Send to: ______________________ (Name of Health Care Provider/Plan/Other)
______________________ (Address of Health Care Provider/Plan/Other)
______________________ (Fax of Health Care Provider/Plan/Other)

**Information to be Disclosed:**
☐ All medical records (specify conditions, treatment, etc.): ______________________
☐ Imaging records: ______________________
☐ All billing records (specify conditions, treatment, etc.): ______________________
☐ Allergy testing/treatment records: ______________________
☐ Specific records/information as follows: ______________________
______________________________________________
______________________________________________

**I do not want the following information disclosed** (as defined applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health Conditions

**Expiration:** This Authorization is good until the following date: ____________.
(Note: If this is left blank, the authorization will expire in twelve (12) months from the date signed.

**Purpose:** ☐ Further Medical Care ☐ Legal Investigation/Action ☐ Insurance Eligibility/Benefits
☐ Personal (at my request) ☐ Other: ______________________

**Your Rights with Respect to this Authorization:** I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to Colorado ENT & Allergy, Medical Records Department, 3030 N. Circle Dr., Ste. 300, Colorado Springs, CO 80909. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date: ____________________. If I fail to specify an expiration date, this authorization will expire in twelve (12) months from the date this form is signed. I understand that authorizing the disclosure of these medical records is voluntary. I do not need to sign this form in order to receive treatment. I understand that I may be charged a fee for record copies. The current copy fee is $14.00 (pages 1-10), $.50 per page (pages 11-40), $.33 per page (pages 41+). 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 privacy regulations.

**Signature of Patient/Legal Representative:** ______________________ Date: ____________

If signed by a person other than the patient, complete the following:
Patient is: ☐ a Minor ☐ Legally Incompetent or Incapacitated ☐ Deceased
Legal Representative is: ☐ Parent ☐ Legal Guardian
☐ Next of Kin/Executor of Deceased
☐ Medical Power of Attorney for Health Care

| **FOR OFFICE USE ONLY** |
|---|
| Signature/ID verified by: ______________________ Date: ____________ |