Authorization to Disclose Medical Record Information

Please send completed form to:
Innovation Medical Group
2095 N. Dolores Road, Cortez,CO 81321
970-564-8086 ● Fax: 970-564-8087
Email: michelle@innovationmedgroup.com

(Office use only):
Completed By: _____
Date: _____
Dept:_____

Patient Information:_____

Patient's Name: _____
Patient's Address: _____D.O.B: _____
City: _____ State: _____ Zip: _____
Phone Number: _____

Release Information:_____

I hereby authorize Innovation Medical Group to: ☐ Send my medical records to: ☐ Request my medical records from:
Name/Facility: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐ Continued Care (Appt. with Specialist) ☐ Legal ☐ Insurance
☐ Transfer of care (New Physician) ☐ Other:_____

Information to be Released: Please specify date ranges

☐ Abstract (generally recommended for transfer of care – includes 3 years of history, notes and test results)
☐ Office Visits _____ to _____ Specify Provider(s): _____
☐ Lab Results: _____ to _____ ☐ Radiology Reports: _____ to _____
(If radiology images are required, please contact the radiology department directly)
☐ Other (please be specific): _____
Statutorily Protected Information
The following items will not be included unless specifically authorized.
☐ Genetic Testing Initial: _____ ☐ Psychiatric Health-including Behavioral Medicine Notes Initial: _____
☐ HIV/AIDS Results Initial: _____ ☐ Alcohol/Drug Abuse Treatment Initial: _____
☐ Sexually Transmitted Diseases Initial: _____

I understand that I have a right to revoke this authorization at any time by providing a written statement to the Medical Records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand this authorization is valid for 12 months unless otherwise specified or revoked. Please specify an expiration date if less than 12 months: ____/____/_____. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that my health record may contain general information related to my mental health, drug/alcohol abuse, or other information that I may consider sensitive. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal confidentiality rules.

Signatures:

Patient/Legal Representative Signature: _____ Date: _____
Print Name of Legal Representative: _____ Relationship to Patient: _____