AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION TO FPA

FAMILY PRACTICE ASSOCIATES, PC **FAX: 303-673-9195**

PATIENT INFORMATION	NAME: ______________________ DATE OF BIRTH: ______________ ADDRESS: ______________________ DAY PHONE: ______________ CITY: ______________________ STATE:__________ ZIP: __________
CLINIC / HOSPITAL HEALTH CARE PROVIDER (***Who*** has the information you want released?) Please list the specific Hospital and/or clinic.	NAME: ______________________ PHONE: ______________ ADDRESS: ______________________ FAX: ______________ CITY: ______________________ STATE:__________ ZIP: __________
RECEIVING PARTY (***Where*** do you want the information sent? ***Who*** may have the information?)	FAMILY PRACTICE ASSOCIATES, PC Phone: 303-673-9090 433 Summit Blvd, Suite 201 Fax: 303-673-9195 Broomfield, CO 80021
INFORMATION TO BE RELEASED (***What*** do you want sent or released? Check the appropriate box.)	**Routine Record Sets** (indicate date(s) of service ______________________) ☐ Clinic (office visit, lab, radiology, medicines, immunizations) ☐ Hospital (operative report, laboratory, radiology) ☐ Billing Records ☐ Imaging Reports ☐ ANY and ALL records types of records listed below. If you want to include images and billing records, check those boxes.) **<u>Only records types checked below</u>**: ☐ History and physical exam ☐ Laboratory reports ☐ Mental health records ☐ Operative report ☐ Radiology reports ☐ Chemical dependency/ Substance abuse records ☐ Progress notes/clinic notes ☐ Pathology reports ☐ Immunization/allergy record ☐ Medication records ☐ Communicable diseases ☐ Other records specify record type(s) ______________________ **OPTIONAL LIMITS:** Disclose only records related to the following: Date(s) of Service:______________ Injury or Illness:______________
RELEASE INSTRUCTIONS (***How*** and ***When*** do you want the information?)	Date information is needed: ______________ (NOTE: Please allow 7-10 days for processing.) Release method / Format requested (check one): ☐ Paper ☐ Fax
PURPOSE OF RELEASE (***Why*** is it needed?)	☐ Continuing care ☐ Transfer of care ☐ Social Security Appeal ☐ Insurance applications * ☐ Personal use or review * ☐ Social Security Disability Determination * ☐ Insurance payment/claim ☐ Litigation/Legal * ☐ Other * ______________________ * Fees may be charged

◆ This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: ______________. This authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation. The Family Practice Associates, PC, Privacy Practice describes how to cancel (revoke) this authorization. Family Practice Associates, PC, will not restrict treatment if I choose not to sign this authorization.

◆A photocopy/fax of this authorization will be treated in the same way as the original. Family Practice Associates, PC, records may include records that it received from other organizations. If these records have been used by Family Practice Associates, PC, and filed in the record Family Practice Associates, PC, maintains about you, these records may be released with your Family Practice Associates, PC, records. Family Practice Associates, PC, cannot prevent redisclosure of your information by person or organization who received your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released.

◆ By signing this authorization, you release Family Practice Associates, PC, from any and all liability resulting from a redisclosure by the recipient.

◆ Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

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Patient/Legal Guardian Signature Date Authority to act on behalf of patient (attach document)