AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ________________

Address: ____

City/State/Zip: ____________________________ Phone Number: ________________

I AUTHORIZE MY MEDICAL RECORDS BE RELEASED FROM:

____
Doctor's Office, Hospital, Clinic, etc.:

____
Address/City/State/Zip

Phone Number: ____________________ Fax Number: ________________________

I AUTHORIZE MY MEDICAL RECORDS BE RELEASED TO:
Westmed Family Healthcare
12201 Pecos Street, Suite 500
Westminster, CO 80234
(P) 303-457-4497 ***(F) 303-254-4369***

Pertinent Protected Health Information Allowed to be Included: (please circle items requested)

Discharge Summary	Radiology	Special Studies	Entire Medical Record
History & Physical/Consult	Outpatient Record	Medication Records	Operative Report
Progress Notes	Psych Health Records	Labs	Physician Orders

Other (specify): ____

For the purpose of: Continuity of Care OR Other: ______________________________

1. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
2. I understand this authorization will expire, without my express revocation, one year from the date of the signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
3. I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents is $18.53 for the first ten pages, $.85 per page for pages 11 through 40 and $.57 per page for each page over 40.

____ ________________________
Signature of Patient or Authorized Personal Representative Date

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PRINT Name of Patient or Representative

Last Revision: October 2, 2017