Authorization for Release of Patient Records

I authorize and request **Kinetic Foot and Ankle Clinic** to transfer, release, or obtain information on:

_____ _____ _____
(Name of Patient) (Date of Birth) (Daytime Phone)

_____ _____
(Patient Address (City, State, Zip)

Obtain From:
_Sharp Podiatric Medicine and Surgery_____
(Physician/Institution Name)
Attention: MEDICAL RECORDS
_10103 Ridgegate Parkway, Suite 309_____
_____
(Address)
_Lone Tree, CO, 80124_____
(City, State, Zip)
_303-662-1600_____303-662-1008_____
_____
(Phone) (Fax)

Purpose of Disclosure:
☐ Change of Physician
☐ Continuation of Care
☐ Referral
☐ Other

Date(s) of Treatment:
☐ All Dates —or—
☐ Specific Dates: _____thru

Please Check Information Requested

☐All Records ☐Progress Notes ☐Operative Report ☐Imaging Reports
☐ER Report ☐Laboratory Reports
☐Other_____

Disclose/Send to: _Kinetic Foot and Ankle Clinic ____ Attention: MEDICAL RECORDS
(Physician/Institution Name)
Address: _12510 E Iliff Ave, Suite 120 _____ City, State, Zip:__Aurora, CO, 80014_____
Phone: _720-295-4864____ Fax:_855-805-9391_

I understand my records may include information relating to: history, diagnosis and/or treatment of sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also contain information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office of Kinetic Foot and Ankle Clinic. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company.

Unless otherwise revoked, this authorization will expire in 1 year from the date signed.
I have read and understand this consent. I request my records be released in the manner specified above.

_____ _____ _____
(Signature of Patient or Patient's Representative) (Relationship to Patient) (Date)

Please note in some instances reasonable copy fees will apply as outlined by HIPAA and Colorado State Law.