

## 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:

\_\_\_\_\_  
(Physician/Institution Name)

**Attention: MEDICAL RECORDS**

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

### Purpose of Disclosure:

- Change of Physician  
 Continuation of Care  
 Referral  
 Other

### Date(s) of Treatment:

- All Dates —or—  
 Specific Dates: \_\_\_\_\_ thru

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Fax)

### Please Check Information Requested

- All Records       Progress Notes       Operative Report       Imaging Reports  
 ER Report       Laboratory Reports  
 Other \_\_\_\_\_

**Disclose/Send to:** \_\_\_\_\_ Attention: \_\_\_\_\_  
(Physician/Institution Name)  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*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 as outlined by HIPAA and Colorado State Law.