Patient information

Patient Name__________________________ Date of Birth ______________ AAIR # __________

Address____

City ______________________ State __________Zip ____________

Phone # ____________________

Release From

I hereby authorize:
( ) AAIR, 120 Midland Ave., Suite. 230, Glenwood Springs, CO 81601
PH(970)947-0600 Fax (970)947-0601
Other: ____
Name (i.e. Health Facility/Physician)
____
Address
____
City/State/Zip Phone Fax

Release to

Release to:
( ) AAIR, 120 Midland Ave., Suite 230, Glenwood Springs, CO 81601
PH(970)947-0600 Fax (970)947-0601
Other: ____
Name (i.e. Health Facility/Physician)
____
Address
____
City/State/Zip Phone Fax

Information to Be Released

(Circle all applicable categories)
- ☐ Complete Copy of All Records ☐ Lab Reports ☐ Skin Test Results
- ☐ Office/Consultation Reports ☐ X-Ray/CT Reports
- ☐ Other (specify)______________________________________

State/Federal Laws require specific authorization to release the following types of information. Please check beside the types of information to be released:
- ☐HIV/AIDS Related ☐ Genetic Testing ☐ Drug/Alcohol Abuse
- ☐ Mental Health ☐ Psychotherapy Notes ☐ Developmental Disabilities

For the Following Dates:______________________________________

Purpose or Need for Disclosure

(Circle all applicable categories)
- ☐ Continuation of Care ☐ Insurance ☐ Personal Use
- ☐ Legal Use ☐ Other (specify)______________________________

Authorization

I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original. I understand the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. My signature on this form is voluntary and I do not need to sign this form to ensure health care treatment. This authorization is valid for 12 months from the date of signature. I understand that I may revoke this authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signature

Patient/Legal Guardian Signature__________________________Date__________________________

Witness Signature____________________________________Date __________________________

Fees

Pages	1-10	11-40	41+
Patient	$14.00	.50 each	.33 each
Others	$16.50	.75 each	.50 each

According to Colorado State Statute, 6 C.C.R. 1011-1, Chapter 2 Part 5.2.3.4 the following fees may be charged for copies of medical records.
Actual postage may be charged
Records will be provided to other health care providers at no charge.

Once AAIR receives your authorization to release information, it will take approximately 7-10 Business days for the record to be photocopied and faxed/mailed to the address you provide. Occasionally delays occur. We will attempt to contact you if extra time is needed to process your request.

AAIR : office use only

Date received:___________ Reviewed: _______________