AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (MEDICAL RECORDS RELEASE)

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

PHONE#: _____

Please release medical records and information FROM: (check one)

☐ Westminster Medical Clinic
8601 Turnpike Drive, #200
Westminster, CO 80031
Phone: (303) 428-7449
Fax: (833) 741-2199

☐ Longmont Family Medicine
1350 Tulip Street
Longmont, CO 80501
Phone: (303) 428-7449
Fax: (833) 741-2199

☐
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Please include the following information: (select all applicable)

☐ Most recent 3 years of record
☐ Entire medical record
☐ Other: _____
☐ Lab results
☐ Imaging (including x-ray, MRI, CT, etc.)

Please send the medical records and information listed above TO: (check one)

☐ Westminster Medical Clinic
8601 Turnpike Drive, #200
Westminster, CO 80031
Phone: (303) 428-7449
Fax: (833) 741-2199

☐ Longmont Family Medicine
1350 Tulip Street
Longmont, CO 80501
Phone: (303) 428-7449
Fax: (833) 741-2199

☐
Name: _____
Address: _____
_____
Phone: _____
Fax: _____

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1. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, sexually transmitted diseases (STDs) and past medical history.
2. I understand this authorization will expire upon completion of this request or on the future date listed here: _____. If no future date is listed, this authorization will expire upon completion of this request. I understand that I may withdraw this authorization in writing at any time except to the extent that action has been taken based on it. I understand that withdrawing this authorization will not apply to information that has already 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 authorize Westminster Medical Clinic to provide the above requested information on a compact disc (CD) in portable document format (PDF) unless otherwise specified. I accept full financial responsibility for copying fees:
   a. Emailed PDF: The fee for electronically copying requested documents is $10.
   b. CD: The fee for electronically copying requested documents onto CD is $15.
   c. PRINT: Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents is $18.53 the first ten pages, $0.85 per page for pages 11 through 40 and $0.57 per page for each page over 40.

_____ _____

Signature of patient or personal representative | Date

_____ _____

Personal representative's name (please print) | Relationship to patient