



3800 Irving St.

Denver, CO 80211

(P) 303-477-6000; (F) 303-975-6629

### Medical Records Release Form

(HIPAA Compliant Authorization to Use or Disclose Protected Health Information)

Today's Date: \_\_\_\_\_

<b>PATIENT INFORMATION</b>
Patient Name: _____ SSN#: _____
Address: _____ Date of Birth: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____

<b>REQUESTING RECORDS FROM</b>
Name of Facility: _____
Phone Number: _____ Fax Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____

<b>SEND RECORDS TO</b>
Urgent Care Solutions Glendale, PC (AFC Urgent Care-Denver Highlands)
3800 Irving St
Denver, CO 80211
(P) 303-477-6000; (F) 303-975-6629

\*If record is more than 10 pages, please mail to the address listed above. If less than 10 pages, please fax the records.

<b>SELECT INFORMATION TO DISCLOSE</b> <input type="checkbox"/> Patient's entire medical record <input type="checkbox"/> Physician patient visit notes <input type="checkbox"/> Laboratory results: ___ All ___ From Date: _____ <input type="checkbox"/> Imaging Results <input type="checkbox"/> Cardiac Studies <input type="checkbox"/> Medication Notes <input type="checkbox"/> Other: _____	<b>REASON FOR REQUEST (check all that apply)</b> <input type="checkbox"/> Transferring to another physician <input type="checkbox"/> Health Insurance company changes <input type="checkbox"/> Copy for personal records <input type="checkbox"/> Legal <input type="checkbox"/> Auto Accident <input type="checkbox"/> Specialist physician referral <input type="checkbox"/> Other: _____
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**AUTHORIZATION OF PATIENT (or Legal Representative)**

I authorize \_\_\_\_\_ (facility of original medical records) to forward a copy of the selected patient medical records to use or disclose Protected Health Information (PHI) for the purpose(s) selected above.

I understand the information in this health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time and if I revoke this authorization or have questions about any disclosure of my PHI, I must do so in writing and present my written revocation to the HIPAA Privacy Officer for the facility of the original medical records.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in ninety (90) days or on the following date or event: \_\_\_\_\_.

I understand that authorizing the disclosure of this PHI is voluntary and I need not sign this form in order to assure treatment.

I understand that I may inspect or copy the information to be used or disclosed, as provide in CFR 164.524.

I understand that any disclosure of information carries with it the potential for an unauthorized red-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the HIPAA Privacy Officer at the facility of origin of the medical record.

**Signature of Patient (or legal Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_