777 E Speer Blvd

Denver, CO 80203

(P) 303-6733-4000; (F) 303-722-3363

Medical Records Release Form

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

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ SSN#: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

REQUESTING RECORDS FROM

Name of Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SEND RECORDS TO

Urgent Care Solutions Glendale, PC (AFC Urgent Care-Denver East)
1295 Colorado Blvd
Denver, CO 80206
(P) 303-639-1000; (F) 720-420-9933

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

SELECT INFORMATION TO DISCLOSE	**REASON FOR REQUEST (check all that apply)**
_____ Patient's entire medical record	_____ Transferring to another physician
_____ Physician patient visit notes	_____ Health Insurance company changes
_____ Laboratory results:	_____ Copy for personal records
___ All ___ From Date: _____	_____ Legal
_____ Imaging Results	_____ Auto Accident
_____ Cardiac Studies	_____Specialist physician referral
_____ Medication Notes	_____ Other: _____
_____ Other: _____	

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 nay 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:** _____