PARKER SQUARE FAMILY PRACTICE
19641 E PARKER SQUARE DR, SUITE E
PARKER, CO 80134
PH 303-805-2222 FAX 303-805-2255

HIPAA AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name (Print): _____ DOB: _____

Social Security Number: _____ Phone Number: _____

Release Records TO: _____ Release Records FROM: _____

Address: _____ Address: _____

_____ _____

Tele: _____ Fax: _____ Tele: _____ Fax: _____

I request and authorize the release of information to the organization, agency, or individual named above. I understand that the information to be released may include the following condition(s):

1. Drug Abuse/Alcohol Abuse (Fed. Reg. 42 C.F.R. Part 2)
2. Psychological or psychiatric condition(s)
3. Test for the presence of antibodies (HIV)/virus which causes AIDS
4. AIDS diagnosis and/or an AIDS condition
5. Any third party source (hospital, specialist, labs, etc.)

***According to Colorado State Status (GCCR 1101-1, Rule XIV), there is a charge for copies of medical records. The charge is $16.50 for the first 10 pages, $0.75/pages 11-39, and $0.50/pages 40 and above.

Information Requested:

____ Entire Record ____Specified Date Range for all Records _____ to _____
____ Doctor's Notes ____X-Ray Reports ____Third Party Records ____Problem List
____ Pathology Reports ____ Diagnostic Studies ____ List of Allergies ____ Rx List
____AIDS/HIV information ____ Immunization Record ____ Drug/Alcohol Abuse
____ Psychological/Psychiatric Evaluations ____ Most recent History and Physical
____ Laboratory Results: All____, or from Date: _____ to _____
____ X-Ray and Imaging Reports: All____, or from Date _____ to _____
____Consultation Reports From Date _____ to _____
____ Other _____

Purpose of Release: _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Site Practice Manager. I understand 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 on the following date, event or condition _____.
I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to comply with it.
In any event, this authorization expires ninety (90) days from the date of signature. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient Date

_____ _____
Witness Signature Date

If patient is unable to sign, please document the reason: _____

INFORMATION REQUESTED WILLNOT BE PROVIDED IF ANY OF THE ABOVE IS NOT COMPLETED.

We use Diversified Medical Records Services to copy all requested material on a weekly basis. To Reach DMRS for further inquiries or status of your request once it has been copied, you may call 800-359-8520.