

Columbine Family Practice, P.C.

AUTHORIZATION FOR RELEASE OF "OUT GOING" MEDICAL INFORMATION

(Print patient's full name)

(Street address)

(City, state, zip code)

(Previous name, if different from above)

Birth date (Mo/Day/Yr)

Social Security Number

Phone (Home)

Phone (Work or Cell)

At the request of the individual, I _____, do hereby authorize **Columbine Family Practice**
(Patient's name)

to release:

____ DISCHARGE SUMMARY _____ PATHOLOGY REPORTS _____ EMERGENCY REPORTS
____ HISTORY & PHYSICAL _____ LABORATORY REPORTS _____ OTHER _____
____ PROGRESS NOTES _____ RADIOLOGY REPORTS
____ OPERATIVE NOTES _____ ECG/EEG/CARDIC CATH

____ I do ____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

Name of Company/Agency/Facility/Person

Street address

City, state, zip
Phone _____ Fax _____

REASON FOR RECORDS REQUEST: ____ Referral, ____ Insurance, ____ Workers Comp, ____ Legal investigation
____ Disability Determination, ____ Change of Doctor (if change of doctor
please state why?) _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for ____ months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual (or Guardian or Personal Representative of patient's estate)

Date: _____
Reviewd by: Name of CFP employee

NOTE: THERE WILL BE A CHARGE FOR A PERSONAL COPY. SMART CORPORATION HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. THERE IS NO CHARGE IF THE PERMANENT TRANSFER IS SENT DIRECTLY TO THE PHYSICIAN'S OFFICE TO WHICH YOU ARE TRANSFERRING.

MEDICAL INFORMATION RELEASED BY SMART CORPORATION

ENTIRE _____ LAB _____ EKG _____
DS _____ EKG _____ IMMUNE _____
OP _____ X-Ray _____ OTHER _____
HP _____ PATH _____
ROI SPECIALIST _____
DATE _____

We appreciate any feedback you might have that has influenced your decision to request your medical records. You can send in a written response to Columbine Family Practice, 7335 so. Pierce St, Littleton, CO 80128 or e-mail us at columbinefp@hotmail.com, or you can call management at 303-979-7200 and speak with Dan Shown the Practice Administrator. Please be candid. It is our goal to address all patient issues and resolve any problems that may have arisen.