

**AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION**  
**COLORADO SPRINGS ALLERGY & ASTHMA CLINIC**

**This release expires 90 days from date of signature or upon patient's written request**

Patient's Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Previous Name Under Which Records May Be Filed: \_\_\_\_\_  
 Patient's Current Address: \_\_\_\_\_  
 Patients's New Address If Moving: \_\_\_\_\_

I specifically authorize any current employee of:  
 Name of Doctor/Facility \_\_\_\_\_  
 Address: \_\_\_\_\_  
 to release my medical records described on this form for the following  
 reason \_\_\_\_\_

I understand that when the information is released, it may be subject to re-disclosure by the recipient and may no longer be protected Personal Health Information (PHI).

Please release my Medical Records To:  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_

Please initial the appropriate to indicate which records you wish to be released and be charged for:  
 Records generated in this office only (not including X-rays, old records, outside lab results). If no box is initialed, this option will be used.  
 Records generated in this office only (including X-rays, old records, outside lab results, which may incur an additional charge).  
 Other: \_\_\_\_\_  
 (specific dates of treatment or specific parts of record).

Patient Signature _____ Date: _____ Or Signature of Legal Representative _____ Date _____ Relationship to patient _____
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**\*\*PLEASE READ BELOW SECTION\*\***

I understand that a separate, expressed consent is required to release sensitive healthcare information in my record, and I specifically request that _____ (name of physician or facility) release any medical information pertaining to testing, diagnosis, and/or treatment for HIV(AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use.  Patient Signature _____ Date _____ (patients 18 years and older must sign for themselves) OR Signature of Legal Representative _____ Date _____ Relationship to Patient _____
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## **MEDICAL RECORD COPYING FEES**

As authorized by Colorado State Statute 6C.C.R 1011-1, Chapter 2, Part 5.2.3.4, the fee for copying medical records is as follows:

<b>\$14.00</b>	<b>for the first 1-10 pages</b>
<b>\$.50</b>	<b>per page 11-40</b>
<b>\$.33</b>	<b>per page for every page thereafter.</b>

Actual postage, if any also may be charged.

**It is required that fee be paid in advance of copying records**

## **TIME REQUIRED FOR COPY MEDICAL RECORDS**

**7-10** days if chart is maintained at the medical office

**10-14** days if chart is maintained off-site in medical records storage facility.

## **PATIENT ACKNOWLEDGEMENT**

I acknowledge and accept the financial terms of copying my medical record as stated above.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**NOTE:** Patients 18 years and older must sign for themselves.