DOCTORS CARE

HIPAA Compliant Authorization For Release of Health Information
RECORDS RELEASE

Patient name: _____ Date of birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information
☐ Immunization records and or Physical Verification Information: _____
☐ My health information relating to the following treatment or condition: _____
☐ My health information for the date(s):_____
☐ Other Specifiy: _____

I specifically authorize disclosure of the following conditions (check all that apply):

☐ Drug abuse ☐ Alcohol abuse ☐ HIV/AIDS ☐ psychological or psychiatric conditions, **including psychotherapy notes**

☐ **I am requesting records to be sent from (include fax number):**

Name (or title) and organization_____

Address: _____City _____State _____Zip_____

Fax Number:

Doctors Care Medical Records Fax number: 303-730-2090

OR

☐ **I am requesting my Doctors Care records to be sent to (include fax number):**

Name (or title) and organization_____

Address: _____City _____State _____Zip_____

Fax Number:_____

Reason(s) for this authorization (check all that apply):

☐ Changing Primary Provider

☐ Further Eval/Treatment/Coordination of Care with other provider

☐ Other (specify)_____

☐ Legal request

This authorization ends: ☐ On (date) _____(if left blank, one year from date of signature

II. My Rights I may revoke this record release authorization in writing. If I revoke this authorization to release records, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to re-disclose it. Privacy laws may no longer protect it.

_____	_____	_____	_____
Patient or legally authorized individual signature	Date	Time	Telephone number

_____	_____	_____
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, legal personal representative)	Telephone number