SMOKY HILL FAMILY MEDICINE
13111 E BRIARWOOD AVE
SUITE 215
CENTENNIAL, CO 80112
303-680-9150 PHONE 303-680-9149 FAX

HIPPA AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name: (print) _____ **Date of Birth:** _____
Social Security Number: _____ **Phone Number:** _____

Release to: _____ **Release from:** _____

_____ _____

_____ _____

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 conditions.
3) A test for the presence of antibodies (HIV)/virus which causes AIDS.
4) An AIDS diagnosis and/or and AIDS related condition.
5) Any third party source (hospital, specialist, lab).

Information requested (please mark all items you authorize to be released)

Doctors notes ☐ Diagnostic studies ☐
Pathology reports ☐ Immunization records ☐
AIDS/HIV information ☐ List of allergies ☐
Psychological/psychiatric evaluation ☐ Drug abuse/alcohol abuse ☐
Laboratory results ☐ Problem List ☐
X-ray and imaging results ☐ Medication List ☐
Consultation reports ☐ **ENTIRE RECORD** ☐
Other _____ Treatment dates _____

Purpose of release _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this information I must do so in writing and present my written revocation to the Privacy Officer. I understand the revocation will not apply to information that has already been released in response to this authorization. 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 one year from this request. 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.

I accept full financial responsibility for copying fees. Per Colorado Department of Public Health Environment Regulations, the fee for copying requested documents is $16.50 for the first ten pages, $0.75 per pages 11 through 40 and $0.50 per page for each page over 40. There is a $5.00 fee to all patients requesting a personal copy of medical records. 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 re0disclosure the information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient or authorized personal representative Date

_____
Personal representatives name (print) and relationship
(please attach applicable legal documentation of authority).

For office use:
Verification of photo ID:
Verified by: