COLORADO PULMONARY ASSOCIATES, P.C.

Authorization for Release of Medical Records

Patient's Name:_____DOB:_____

I hereby authorize the release of medical records as detailed below FROM:

Colorado Pulmonary Associates
1601 E. 19th Ave Ste 3100
Denver CO. 80218
Phone: 303-863-0300
Fax: 303-863-7014

TO:

Name of the Provider/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

I authorize the release of:

( ) All my health information maintained by the above named practice or physician, including any health information related to drug abuse, alcohol, HIV/AIDS, and psychological or psychiatric conditions, including psychotherapy notes. If I **DO NOT** authorize the release of those types of sensitive health information, I will indicate that here with my initials: _____.

OR:

( ) My health information related to the following specific condition, treatment, or date(s):

Reason for authorization:

( ) Continuation of Care ( ) Insurance ( ) Legal ( ) Personal Use ( ) Other

My rights: I understand that I may revoke this authorization in writing at any time, except to the extent that the action has already been taken to comply with. I understand that this authorization will not apply to admission of care provided after the date of my signature. Even if I do not revoke this authorization in writing, this authorization will automatically expire:

( )180 Days from the date of my signature
( ) On the following date: _____

_____ _____

Signature of Patient or Guardian Date