COLORADO PULMONARY ASSOCIATES, P.C.

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Please read all information and instructions before completing and signing the authorization form**

Patient's Name_____Birth date_____
(please print) LAST FIRST MI

| INFORMATION TO BE RELEASED ***BY*** | INFORMATION TO BE RELEASED ***TO*** |
|---|---|
| Colorado Pulmonary Associates, P.C.<br>1601 E. 19th Avenue, Suite 3100<br>Denver, CO 80218<br>Phone: (303) 863-0300 Fax: (303) 863-7014 | _____<br>Organization/Person Name<br>_____<br>Street Address<br>_____<br>City, State and Zip<br>_____<br>Phone Fax |

TYPE OF MEDICAL INFORMATION REQUESTED:
☐ All Records ☐ Billing Records ☐ Other_____

REASON FOR REQUEST:
☐ Personal ☐ Transfer of Care ☐ Disability ☐ Insurance ☐ Legal Review ☐ Continuing Care

1. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.
2. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits
3. You have the right to revoke or cancel this authorization, in writing, at any time.

**This authorization expires_____(date or event). Authorization will expire in 90 days if not otherwise specified.**

**My signature below indicates that I hereby agree to and authorize the release of patient health information to the above-named person or organization.**

**Patient signature**_____ **Date**_____

Internal Use Only
Date Received: _____ Date Processed: _____ ❑ Mailed ❑ Faxed ❑ Handed to patient
Content Sent: _____ Initials: _____