Patient Information:

Patient Legal Name_____ Birth date_____ SS# _____

Address/City/State/Zip_____

Telephone number:_____ Cell Number:_____

Release From:

I hereby authorize:

Name/ Title/ Organization

Address/City/State/ Zip

To Release To:

O Colorado injury Treatment Center, PC

O Other_____

Purpose:

O Continuation of care O Insurance or Worker's Comp O Legal O Personal use O Treatment

Other_____ For Treatment date(s)_____

Access Requested:

O Copies of the records

O Inspection of the record

Pertinent Information

O D/C Summary O H & P

O Consult/Operative Report

O Lab/ Radiology

O Emergency Room Record

Selected Portions:

O Outpatient Visit O Diagnostics

O Special Studies O Entire Medical Record

O Physician Orders O Billing Record

O Medication Record O Other_____

Patient Authorization:

ACKNOWLEDGEMENT: I request and authorize the above-named health care provider to release the information specified above to the organization or individual named on this request. I understand that the information to be released may include information reguarding the following condition(s). Sickle Cell Anemia; Genetic testing; Human Immunodeficiency Virus (HIV); Drug Abuse, Alcoholism, Alcohol Abuse, if any; Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any

I understand that:

1. My signature on the is form is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy of Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longfer be protected by federal privacy regulations.
4. Fees/charges will comply with all laws and regulation applicable to release of information.

Fees:

Note: Colorado Injury Treatment Center, PC may charge a fee for copies of the medical records in accordance to Colorado State Law.

Delivery Instructions:

O Call requestor for pick-up when records are ready O Fax Records_____

O Mail Records directly to person or prganization specified

Confirmation of PICK-UP

O I authorize _____ to pick up my Protected Health Information(PHI)

(print name)

Relationship

Signature

Date

Signature:

My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability or enroll for benefits will not be affected.

Date Patient or Authorized Representative Relationship to patient

A copy is provided after signature.

EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfacation of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified as follows:_____

OTHER CONDITIONS: A copy or facsimile off this Authorization with my signature may be used with the same effectiveness as an original.

COLORADO Injury Treatment Center, PC

Authorization for Use and Disclosure of Protected Health Information (PHI)

CITC USE ONLY

Verification:

Date Authorization received_____ BY:_____

Date Requested Completed_____BY:_____

Identification/driver's License # verified_____

O other_____