



HIPAA Authorization for Release of Patient Information

Written Records Verbal patient medical information

Patient (print) _____ DOB _____ M_F

Phone number (____) _____ day (____) _____ evening

Release TO: The Eye Center
2480 S. Downing St., Ste 100
Denver, CO 80210
(303) 777-5455ph (303) 777-1175 fax

Release from: _____

Address: _____

Phone(____) _____

fax (____) _____

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):

- Drug Abuse/Alcohol Abuse (Fed. Reg. 42 C.F.R., Part 2)
• Psychological or psychiatric conditions
• A test for the presence of antibodies (HIV) virus which causes AIDS

According to Colorado State Statutes (GCCR 1101-1, Rule XIV), there is a charge for copies of medical records. The charge is \$14.00 for the first 10 pages, \$.50/pages 11-39, and \$0.33/pages 40 and above.

Information requested (Please mark the box for all items you authorize to be released):

- Most recent History and Physical
Third party record
AIDS/HIV information
List of allergies
Laboratory results
EKG w/interpretation
X-ray & image reports
Consultation reports
Entire record
Other
Doctor's notes
Pathology reports
Immunization record
X-ray reports
Drug Allergies
Drug abuse/alcohol abuse
Contact/Glasses Rx
Diagnostic studies

Other _____

from date _____ to date _____

from date _____ to date _____

from date _____ to date _____

Other _____

Treatments date(s): _____

Purpose of release: Eye surgery Other _____

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Site Practice Manager. 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 on the following date, event or condition:

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. In any event, this authorization expires ninety (90) days from the date of signature. I release the above 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 re-disclosure and the information may not be protected by federal confidentiality rules.

Signature of patient _____

Date _____

Witness _____

Signature of legal guardian/executor _____

If patient is unable to sign, please document reason:

Thomas P. Larkin, M.D. Jenna M. Manning, O.D. Michael L. Miller, M.D.
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(303) 777-5455 WWW.Eyecarecolorado.com (303) 777-1175 fax