# Colorado Osteopathic & Integrative Medicine Associates, PC

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*It's about Health….isn't it about Time!™*

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

As required by HIPAA, this office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information.

Patient Name: ______________________________ Birth Date: ____________________

Patient's Address: ________________________________________________

I hereby request and authorize ________________________________________

________________________________________________________________

to release Medical Records to:

**COIMA, PC, 4901 W. 38th Avenue, Denver, CO 80212**

# ***PLEASE DO NOT FAX MORE THAN 15 PAGES***

I understand that the records to be released may include information pertaining to the following condition(s): Drug Abuse/Alcohol Abuse, Psychological or Psychiatric Conditions, HIV test results, or an AIDS diagnosis and or an AIDS related condition.

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Treatment Date(s) ________________________________________

Purpose of Release: ________________________________________

Information Requested (check if to be released):

☐ Complete Chart
☐ Progress Notes
☐ Imaging ________________________________________
☐ Physical Therapy Reports
☐ Medication
☐ Labs
☐ Other________________________________________

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected by HIPAA.

I understand that I may revoke this authorization at any time by contacting Colorado Osteopathic & Integrative Medicine Associates, PC. at the above address. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I certify that this request has been made voluntarily.

I understand I have a right to obtain a copy of any information disclosed pursuant to this authorization and that there may be fees associated with this request if I request copies for my own use per Colorado regulations as follows: $14.00 for the first ten or fewer pages, $0.50 per page for pages 11-40 and $0.33 per page for every additional page.

I understand that this authorization will automatically expire 365 days from date of signature or as follows: ______________________

______________________________ ____________

Signature of Patient/Guardian/Patient Representative Date