The Centeno-Schultz Clinic
403 Summit Blvd. # 201
Broomfield, Colorado 80021
Phone: 303-429-6448/ Fax: 303-429-6373

HIPAA AUTHORIZATION FOR MEDICAL RECORDS

Written Records *Verbal Patient Medical Information*

Please Print

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Release **TO:** _____ Release **FROM**: _____

Address: _____ Address: _____

Phone: _____ Fax: _____ 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),

1) Drug Abuse/Alcohol Abuse (Fed Reg.42 CFR, part 2)
2) Psychological or psychiatric conditions
3) A test for the presence of antibodies (HIV) virus which causes AIDS
4) An AIDS diagnosis and/or AIDS related condition
5) Any third party source (hospital, pc, lab)

***According to Colorado State Statutes (**GCCR 1101-1, 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 $.33/pages 40 and above.

Information Requested (Please circle for all items you authorize to be released):

Entire Record X-ray reports Pathology reports

Doctor Notes Third party record Diagnostic Studies

Psychological/psychiatric evaluations

Other _____

Treatment Dates: _____

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 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 extend that action has already been taken to comply with it. *In any event, this authorization expires ninety (90) days form the date of signature. I release the above name form 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_____

OR

Signature of legal guardian/executor _____ Date_____