Medical Records Release & HIPAA Authorization Form

I, _____ _____/_____/_____ , **authorize**
Patient's First & Last Name — Patient's Date of Birth

Gastroenterology of the Rockies and its employees to use and/or disclose my Protected Health Information from:

_____/_____/_____ **to** _____/_____/_____ **as indicated below to:**
Date (mm/dd/yy) — Date (mm/dd/yy)

Name of Person and/or Company_____

Phone # _____ Fax # _____

Address _____

City _____ State_____ Zip_____

Information To Be Released:

- ☐ Office Visits / Progress Notes
- ☐ X-ray / Imaging Reports
- ☐ Pathology / Lab Reports
- ☐ Insurance / Billing Information
- ☐ Hospital / Operative / Procedure Reports
- ☐ Other_____

We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment. When we use or disclose your health information to other parties as you have instructed in this authorization, we will not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by federal and state privacy laws.

I understand the following: Without my express revocation, this authorization will automatically expire 365 days from the date signed below, unless I request an expiration date less than 365 days. I may choose to revoke this authorization at any time, except to the extent that the action has already been taken to comply with it, by notifying Gastroenterology of the Rockies in writing.

I have a right to receive a copy of this authorization upon my requesting it.

_____ _____/_____/_____
Patient's or Legally Authorized Person's Signature — Date (mm/dd/yy)

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