Youth Clinic

1200 E Elizabeth Street ~ Fort Collins, CO 80524 ~ Ph 970.416.6267 ~ Fax 970.482.2635

Authorization for Release of Information

Patient Name _____
LAST FIRST MI MAIDEN / OTHER NAME

Date of Birth _____ Medical Record # _____
(Office Use Only)

Address _____ City _____ State ____ Zip _____

Daytime Phone _____ Evening Phone _____

I hereby authorize the release of medical records as indicated below:

Released **from**:

Name _____

Address _____

_____

Phone _____

Fax _____

Released **to**:

Name _____

Address _____

_____

Phone _____

Fax _____

Information to be released

- ☐ History and physical exam
- ☐ Progress notes
- ☐ Lab reports
- ☐ X-ray reports
- ☐ Other: _____

Dates requested

_____
_____
_____
_____
_____

ONLY THE PAST 5 YEARS OF RECORDS ARE PROVIDED UNLESS OTHERWISE REQUESTED

I specifically authorize the release of information relating to:

- ☐ Substance abuse (including drug and alcohol abuse)
- ☐ Mental health (including psychotherapy notes)
- ☐ HIV related information (AIDS related testing)

_____
Signature of Patient, Parent or Legal Guardian Date

Purpose of Disclosure

Is patient transferring out of the practice ____ Yes ____ No

If **yes**, please indicate the reason

- ☐ Change of insurance
- ☐ Moving out of area
- ☐ Family consolidation
- ☐ Aged out
- ☐ Unhappy with care of service

Name of new insurance carrier _____

If **no**, please indicate the reason

- ☐ Specialist
- ☐ Consultation / second opinion
- ☐ Personal use
- ☐ Other (please specify) _____
- ☐ Legal
- ☐ Insurance request
- ☐ Verbal exchange only

PLEASE NOTE - A fee will be charged for records copied for legal, personal and insurance company requests.

(continued)

I understand the following:

1. This authorization will expire one year after the date this form is signed.

2. I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.

3. Information used or disclosed pursuant to this authorization may be subject to redisclosurer by the recipient and will no longer be protected by Federal privacy regulations.

4. I am being requested to release this information by _____ (print name of provider) for the purpose of:

   _____

   a. By authorizing this release of information, my health care and payment for my healthcare will not be affected if I do not sign this form.
   b. I understand I may see and copy this information described in this form if I ask for it and that I will get a copy of this form after I sign it.
   c. I have been informed that _____(print provider name) ☐ will ☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

5. Compliance with Colorado statute, I will pay a fee of $ _____ (print fee charged). There is no charge for medical records if copies are sent to the facilities for ongoing care or follow up treatment.

INCOMING RECORDS ONLY

Your provider will review these records and the contents felt to be clinically useful will be scanned to your electronic health record. <u>It is impractical for FCYC to store or scan the entire file. We encourage you to keep these records for your own files and future needs.</u> Please select one of the following options. Option A is recommended.

____ **A. After selective parts of the transferred record are scanned to the electronic health record, I agree to pick these up within 30 days, after being notified, and retain for my own records.**

____ **B. After Selective parts of the transferred record are scanned to the electronic health record, I give my permision for FCYC to shred the entire copy of the record.**

Signature of Patient	Date	Signature of Parent or Legal Guardian	Date
Records Received By	Date	Relationship to Patient	

FOR OFFICE USE ONLY

Date Request Filed _____ By _____

Identification Presented _____ Fee Collected _____