Aspen Family Care

Medical Record Release Form

9331 S. Colorado Blvd, Suite 200 ~~ Highlands Ranch, CO 80126
(303) 471-4711 ~~ (303) 471-4767 (fax)

Authorization to Use or Disclose My Health Information

Patient name:_____DOB:_____

I authorize the following physician or facility to release my medical records:_____

Phone #:_____ Fax # _____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

- ❒ All my health information maintained by the above-named practice for the **last 2 years.** I understand that this may include records relating to drug abuse, alcohol abuse, HIV/AIDS, psychological/psychiatric conditions including psychotherapy notes.
- ❒ Other:_____

Please release my medical records to the following:

- ❒ Aspen Family Care
  9331 S. Colorado Blvd. Suite 200
  Highlands Ranch, CO 80126
  (303) 471-4711/Fax: (303) 471-4767
- ❒ Other:
  Name: _____
  Address:_____
  City:_____State:_____Zip:_____
  Phone #:_____Fax:_____

Reason(s) for this authorization (check all that apply):

- ❒ At my request
- ❒ Transferring care
- ❒ Other:

Please note that if your medical records are too large to fax or if you request a paper copy, you will have the option to pick up the records from our office or incur the cost for postage.

Please provide records in following format (select one):

- ❒ Pick up a thumb drive
- ❒ Pick up paper copies
- ❒ Contact for postage fees

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office. **OR**
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. This authorization will remain valid for one year from the date of my signature.

_____ _____

Patient or legally authorized individual signature **Date**