Columbine Family Practice, P.C.

AUTHORIZATION FOR RELEASE OF OUTGOING MEDICAL INFORMATION

_____ (Print **patient's** full name)

_____ Birth date (Mo/Day/Yr)

_____ (Street address)

_____ Social Security Number

_____ (City, state, zip code)

_____ Phone (Home)

_____ (Previous name, if different from above)

_____ Phone (Work or Cell)

At the request of the individual, I _____, do hereby authorize **Columbine Family Practice, PC**
(Patient's name)

to release:

_____DISCHARGE SUMMARY	_____PATHOLOGY REPORTS	_____EMERGENCY REPORTS
_____HISTORY & PHYSICAL	_____LABORATORY REPORTS	_____OTHER_____
_____PROGRESS NOTES	_____RADIOLOGY REPORTS	_____
_____OPERATIVE NOTES	_____ECG/EEG/CARDIC CATH	_____

_____ I do ____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO:

_____Name of Company/Agency/Facility/Person

_____Street address

_____City, state, zip

Phone_____ Fax_____

REASON FOR RECORDS REQUEST: ____Referral, ____Insurance, ____Workers Comp, ____Legal investigation

____Disability Determination, ____Change of Doctor (if change of doctor

please state why?) _____

_____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for __ months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ Date:_____
Signature of individual (or Guardian or Personal Representative of patient's estate)

_____Date:_____
Reviewd by: Name of CFP employee

NOTE: THERE WILL BE A CHARGE FOR A PERSONAL COPY. SMART CORPORATION HAS BEEN CONTRACTED TO PROVIDE THIS SERVICE AND WILL INVOICE YOU DIRECTLY. THERE IS NO CHARGE IF THE PERMANENT TRANSFER IS SENT DIRECTLY TO THE PHYSICIAN'S OFFICE TO WHICH YOU ARE TRANSFERRING.

MEDICAL INFORMATION RELEASED BY HEALTHPORT

ENTIRE_____	LAB_____	EKG_____	_____
DS_____	EKG_____	IMMUNE_____	ROI SPECIALIST
OP_____	X-Ray_____	OTHER_____	_____
HP_____	PATH_____	_____	DATE