Patient Information:

Patient Legal Name _____ Birthdate _____ SS# _____

Address/City/State/Zip _____

Telephone number: _____ Unit Number: _____

Release From:

Keil Urogynecology
PO Box 461292
Denver, CO 80246

Release To:

_____
Name / Title / Organization

_____
Address/City/State/Zip
Telephone# _____ Fax# _____

Purpose:

☐ Continuation of Care ☐ Insurance or Worker's Comp ☐ Legal ☐ Personal Use
☐ Other _____ For treatment date(s): _____

Access Requested:

☐ Copies of the record
☐ Inspection of the record

Pertinent Info:

☐ D/C Summary 9 H&P
☐ Consult/Operative Report
☐ Lab/Radiology
☐ Emergency Room Record

Selected Portions:

☐ Outpatient Visit
☐ Special Studies
☐ Physician Orders
☐ Medication Record
☐ Behavioral Health Record
☐ Entire Medical Record
☐ Billing Record
☐ Other _____

Patient Authorization:

ACKNOWLEDGEMENT: *I request and authorize the above-named health care provider to release the information specified above to the organization or individual named on this request. I understand that the information to be released may include information regarding the following condition(s): Sickle Cell Anemia; Genetic testing; Human Immunodeficiency Virus (HIV); Drug Abuse, Alcoholism, Alcohol Abuse, if any; Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any*

I understand that:

1. My signature on this form is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy of Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations.
4. Fees/charges will comply with all laws and regulations applicable to release of information.

Fees:

Note: KEIL UROGYNECOLOGY may charge a fee for copies of the medical records in accordance to Colorado State Law.

Phys Concurrence: If Applicable:

PHYSICIAN CONCURRENCE FOR PATIENT ACCESS:

_____ has my permission to ***(inspect) (receive copies of)*** the requested medical records. I have reviewed the medical record(s) and have determined they ***(do) (do not)*** contain information relative to psychological or psychiatric problems, which, if revealed to the patient, would be reasonably likely to endanger the life or physical safety of the patient or another person. (If the patient has requested psychotherapy notes, such disclosure ***(would) (would not)*** have significant negative psychological impact upon the patient.)

Attending physician or designee: _____ Date: _____

Delivery Instructions:

☐ Fax records.
Mail records directly to person or organization specified.

☐ I authorize _____ (Print Name) to pick up my Protected Health Information (PHI).

_____
Relationship

Confirmation of PICK-UP

_____
Signature

_____
Date

Signature:

My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

_____
Date — Patient or Authorized Representative — Relationship to Patient

A copy is provided after signature.

EXPIRATION: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 180 days from the date hereof, unless otherwise specified as follows: _____

OTHER CONDITIONS: A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original.

Authorization for Use and Disclosure of Protected Health Information (PHI)

OFFICE USE ONLY
Verification:
Date Authorization Received: _____ By: _____
Date Request Completed: _____ By: _____
Identification/Driver's License # Verified: _____
☐ Power of Attorney ☐ Other _____