



Gastroenterology of the Rockies

MEDICAL RECORDS RELEASE FORM

I, _____, authorize
Patient's Name Patient's Date of Birth
Gastroenterology of the Rockies and its employees to disclose my Protected Health Information
from _____ **to** _____ **as indicated below to:**
Date (mm/dd/yyyy) Date (mm/dd/yyyy)

Name of Person and/or Company

Daytime Telephone # Fax Telephone #

Address

City State Zip

INFORMATION TO BE RELEASED

- Office Visit / Progress Notes
- Pathology / Lab results
- Hospital / Operative / Procedure reports
- X-ray / Imaging reports
- Insurance / Billing Information

I specifically authorize disclosure of the following conditions (check all that apply):

- Drug Abuse
- Alcohol Abuse
- Genetic Testing
- HIV / AIDS
- Sickle Cell Anemia

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 and 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 or legally authorized person(s)signature Date