Authorization for Release or Obtaining Medical Records

Colorado Eye Institute
9320 Grand Cordera Parkway, ste 250
Colorado Springs, CO 80924
Phone: 719-258-1240 Fax: 719-282-1247

Patient Name:_____ **Date of Birth:**_____

Patient Address:_____ **City:** _____**State:**_____

Zip Code: _____ **Email:**_____

Releasing or Requesting Records

- I authorize _____ to release my medical records to Colorado Eye Institute. Phone #:_____ Fax #:_____

- I authorize Colorado Eye Institute to release my medical records to _____.
  Phone #:_____ Fax #:_____

Information Releasing or Requesting

Federal laws require specific authorization to release the following types of information.
_____ ALL medical records at this facility (including notes from other physician's offices).
_____ Only records generated at the facility (not including records received from other sources but to include all diagnostics testing).
_____ Only some portion of records (specified below).
I understand that if I am requesting Medical Records for myself (as opposed to a physician's office requesting them) that the fee for medical records allowed by law is as follows:

Cost for:	Insurers, attorneys and individuals other than the patient or the patient's "personal representative"	Patient and patient's "personal representative"
1st 10 pages	$18.53	$14.00
Pages 11-40	$.85 per page	$.50 per page
Pages 41+	$.57 per page	$.33 per page
Microfilm	$1.50 per page	$1.50 per page

Patient/Authorized Representative Authorization

I understand the following; My signature on this form is strictly voluntary/ I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. If the requestor or receiver is not an insurance company or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. 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. I may inspect or obtain a copy of the health information that I am being asked to disclose.

_____

SIGNATURE REALTIONSHIP TO PATIENT DATE