COLORADO RETINA
COLORADO RETINA ASSOCIATES, P.C.

PATIENT AUTHORIZATION TO REQUEST MEDICAL RECORDS

Patient to provide complete/accurate information, CRA will only process a valid/complete authorization form.

PATIENT INFORMATION:

LAST NAME _____ FIRST NAME _____ MI _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

I AUTHORIZE RELEASE OF: (*Check ONE of the following*)

1. ☐ ALL HEALTHCARE RECORDS 2. ☐ TREATMENT OF (IDENTIFY CONDITION):
3. ☐ TREATMENT RECEIVED ON THE FOLLOWING DATES: START DATE _____ END _____
4. ☐ OTHER (*describe, includes images*): _____

Sensitive records require specific patient authorization. **INITIAL THE APPROPRIATE RECORDS REQUESTED:**

I authorize the information listed below to be disclosed: ***(initial below)***

X _____ Mental Health **X** _____ STD'S (including HIV/AIDS) **X** _____ Drug/ Alcohol Abuse

REQUEST FOR MEDICAL RECORDS: I AUTHORIZE THE BELOW PROVIDER/CLINIC TO RELEASE MY MEDICAL RECORDS TO COLORADO RETINA ASSOCIATES, Fax: 303-261-1601

CLINIC NAME _____ PROVIDER NAME _____

PHONE _____ FAX NUMBER _____

PURPOSE OR NEED FOR WHICH INFORMATION IS TO BE USED: *(check one)*

☐ Damage/Claim Evaluation and Presentation ☐ At Request of the Individual ☐ Other: Litigation

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire upon satisfaction of the need for disclosure or if revoked in writing by the patient, but in any event on _____(*date supplied by patient*) or _____ days hereafter; or under the following conditions if they occur prior to the specific expiration date set forth above:

X Patient Signature _____ **X Date** _____

HIPAA Required Statement: I understand that non-research treatment may not be conditioned upon signing this release. I understand that the information provided under this release may be subject to redisclose by the receipt under circumstances no longer protected by HIPAA privacy rules. I understand that I may revoke this release at any time, except to the extent that action has already been taken to comply with it. To revoke this authorization, I must provide written notice to the doctor or health care provider named in the release and written notice to the organization or entity to whom I have authorized the release of information.