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AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

From: _____

Patient Name: _____

Social Security Number: _____ **Date of Birth:** _____

To: _____

Address: _____

INFORMATION TO BE RELEASED

_____ **I do** _____ **I do not** authorize the release of information related to HIV/AIDS, psychological or psychiatric conditions, and treatment for alcohol and/or drug abuse.

Release the following records:

_____ All medical records at this facility (not including records from other sources)

_____ Only some portion of records maintained at facility (specify below)

_____ _____

REQUEST FOR RECORDS FOR PERSONAL USE MAY BE SUBJECT TO A FEE:

There will be a charge for personal copy of your records from Advanced Neurology of Colorado. The fee schedule is: (Patient and Patient's "personal representative") $14.00 for ten (10) or fewer pages, $0.50 per page for 11-40, $0.30 per page after 40 pages, plus postage (Insurers, attorneys and individuals other than the patient or the patient's "personal representative") $16.50 for ten (10) or fewer pages, $0.75 per page for 11-40, $0.50 per page after 40 pages, plus postage.

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time.

Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

I hereby authorize the use or disclosure of the health information described in this authorization. I understand that if anyone who receives my health information is not a health care provider or a health plan, my health information may not be protected by federal privacy laws if my health information is re-disclosed by that recipient person or physician office.

Patient or legally authorized individual signature _____ **Date** _____

Printed name of patient or person signing on behalf of patient _____ **Relationship (self/parent/legal guardian/etc)** _____