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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 redisclosed 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)**

_____ _____