Phone: 719-960-0363
Fax: 719-413-5966

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this form, I authorize the Physician/Facility/Entity listed below to release/obtain confidential health information about me, by either releasing my medical records to or from Colorado Springs Cardiology.

PATIENT INFORMATION:

Patient Name: _____ DOB: _____ Last 4 of SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

☐ **RELEASE RECORDS FROM COLORADO SPRINGS CARDIOLOGY:** Please specify where records are being released to below.

☐ **SEND RECORDS TO COLORADO SPRINGS CARDIOLOGY:** Please specify where records are requested/obtained from below.

1625 Medical Center Point Ste. 240
Colorado Springs, CO 80907
Fax: 719-413-5966

☐ **RELEASE RECORDS TO PATIENT/SELF:** Select an option below.

☐ Mail ☐ Pick-up -North Campus ☐ Pick-up -Central Campus ☐ Pick-up –Pueblo Campus ☐ Pick-up –Canon City Campus

INFORMATION TO BE RELEASED/OBTAINED:

☐ Complete Record ☐ Progress Notes ☐ Imaging Report: _____
☐ History & Physical ☐ Lab Reports ☐ CD of Imaging: _____
☐ Other: _____

Release Records From: (Dates) _____ to _____

Facility/Provider Name: _____
Address: _____ City: _____
State: _____ Zip: _____Phone: _____ Fax: _____

PURPOSE OF RELEASE:

☐ Further Medical Care ☐ Personal Use ☐ Legal Investigation/Action ☐ Insurance/Disability Eligibility

☐ Other: _____

Your Rights Regarding This Authorization: I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send it to **Colorado Springs Cardiology Medical Records Department at 1625 Medical Center Pointe, Suite 240 Colorado Springs, CO 80907.** I understand that revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, this authorization will expire twelve (12) months from the date this form is signed. I understand that authorizing the disclosure of medical records is voluntary, and I do not need to sign this form in order to receive treatment.

_____ _____

Signature of Patient/Authorized Representative: **Date:**

If signed by a person other than patient, complete the following: (Legal POA/MDPOA is required if signed by anyone other than patient)

Patient is:

☐ Legally Incompetent or Incapacitated
☐ Deceased -Next of Kin/Executor (Death Certificate Required)

Authorized Representative is:

☐ Medical Durable Power of Attorney (MDPOA)
☐ Legal Guardian

For Office Use Only:
Signature/ID Verified By: _____ Date: _____