Aspen Family Care

Medical Record Release Form

9331 S. Colorado Blvd, Suite 200 ~~ Highlands Ranch, CO 80126
(303) 471-4711 ~~ (303) 471-4767 (fax)

Authorization to Use or Disclose My Health Information

Patient name:_____DOB:_____

I authorize the following physician or facility to release my medical records:_____

Phone #:_____ Fax # _____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

- ❒ All my health information maintained by the above-named practice. I understand that this may include records relating to drug abuse, alcohol abuse, HIV/AIDS, psychological/psychiatric conditions including psychotherapy notes.
- ❒ My health information relating to the following treatment or condition:_____
- ❒ My health information for the date(s):_____
- ❒ Other:_____

Please release my medical records to the following:

❒ Aspen Family Care
9331 S. Colorado Blvd. Suite 200
Highlands Ranch, CO 80126
(303) 471-4711/Fax: (303) 471-4767

❒ Other:
Name: _____
Address:_____
City:_____State:_____Zip:_____
Phone #:_____Fax:_____

Reason(s) for this authorization (check all that apply):

- ❒ At my request
- ❒ Transferring care
- ❒ Other:

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR**
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office. **OR**
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. This authorization will remain valid for one year from the date of my signature.

_____ _____

Patient or legally authorized individual signature **Date**