

Authorization to Disclose Protected Health Information from Colorado Eye Gallery

Patient Name: _____ Date of Birth: _____

Request and Authorize: Colorado Eye Gallery

DENVER

5026 E. Hampden Ave.

Denver, CO 80222

P 303-756-5900

F 303-756-5902

BROOMFIELD

520 Zang St. Ste I

Broomfield, CO 80021

P 720-887-6066

F 720-887-5866

BOULDER

6545 Gunpark Dr. # 250

Boulder, CO 80301

P 303-530-1973

F 720-638-1223

Release Information to:

Office/Provider

Fax

Purpose of Request: *Continuation of care* _____

Information to be Released: *Clinical records relating to eyecare*

Most recent visit/encounter

All visits/full record

Request Timeline: *Standard (five business days)* *Urgent*

1. I authorize the release of my medical record, including photographs.
2. This authorization is voluntary, and the disclosure is made at my request.
3. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
4. Multiple requests are authorized if the purpose of the request remains the same.
5. I have a right to revoke this authorization at any time, and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
6. I need not sign this form to ensure health care treatment.

This authorization expires 180 days from the date signed below.

Signature of patient or legal representative

Date