Village Family Practice
5161 East Arapahoe Road Suite #290
Centennial, CO 80122
(720) 488-0055 Fax (720) 488-3955

Patient Name: _____ Date of Birth: _____ Phone #: _____

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

I authorize the following facility: (Releasing facility)

_____
(Facility/Provider Name)

_____
(Complete Address, City, State, Zip)

_____
(Phone #)

To release information to: (Receiving entity)

_____
(Facility/Provider Name)

_____
(Complete Address, City, State, Zip)

_____
(Phone #)

Information requested (check all that apply):

Date of service range (month/year): From:_____ To: _____

( ) Complete Chart ( ) History and Physical ( ) Diagnostic Studies ( ) Laboratory Reports
( ) Radiology Reports ( ) Pathology Reports ( ) Progress Notes ( ) Operative Reports
( ) Mental Health Treatment _____ (Initial) ( ) Drug/Alcohol Treatment _____(Initial) ( )HIV/AIDS Info_____(Initial)
( )Other (must specify): _____

Purpose of Release: ( )Treatment/Diagnosis ( )Insurance ( )Legal ( )Other: _____

Authorization: I herby give the releasing facility permission to disclose my protected health information as listed above. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment can not be conditioned upon my signing this authorization. I acknowledge that incomplete forms can not be processed and that there may be a cost to copy the records.

I understand that this consent expires 180 days from the date of my signature unless otherwise specified as follows: _____. I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/event of expiration, and that the written revocation must be signed and dated with a date that is later than the date of this authorization. A copy, fax or scan of this form is to be considered as valid as the original.

_____ _____ _____
Signature of Patient/Guardian/Personal Representative Relationship Date

_____ (*If patient is unable to sign document for any reason*) _____
Witness Signature Date

Note: The process may take up to 30 days to provide this information. According to Colorado State Statutes, there may be a fee associated with your request, which may be required in advance. The charge is $16.50 for the first ten or fewer pages, $0.75 per page for pages 11-40, and $0.50 per page for every additional page. Actual postage or shipping costs and applicable sales tax, if any, may also be charged.