Medical Records Release Form

I hereby authorize the use or disclosure of health information from the medical record of:

Patient Name _____
Date of Birth_____/_____/_____ Best Contact telephone #_____

I authorize **Academy Allergy Asthma and Sinus Center**, **ASHOK, P.C., Dr. Ashok Rambhai Patel** to release confidential health information about me, by releasing a copy of my medical records, a summary or narrative of my protected health information, or verbally to the individual or organization listed below.

Specific Description of the Information to be released:
Entire Medical Records _____ Or Specific Medical Record _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
☐ **Yes**, I consent to the release of this information.
☐ **No**, I do not consent to the release of this information.

This information may be disclosed to and used by the following individual or organization:

Name:_____

Address:_____

City:_____State:_____Zip:_____

Phone:_____Fax: _____

The reasons or purposes for this release of information are as follows:

_____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. However, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I hereby acknowledge this consent is voluntary. I release, discharge and agree to hold harmless Academy Allergy Asthma and Sinus Center, ASHOK, P.C., Dr. Ashok Rambhai Patel from any liability that may arise from the release of information as authorized above.

I understand that I may revoke this authorization at any time by notifying Academy Allergy Asthma and Sinus Center, ASHOK, P.C., Dr. Ashok Rambhai Patel in writing. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that a photocopy of this authorization is considered acceptable in lieu of the original. I understand I may be charged a reasonable fee in accordance with regulations governed by the Colorado Department of Public Health & Environment.

Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

Signature of Patient: _____ **Date:** _____

Signature of Legal Representative: _____

Relationship to Patient (If Legal Representative): _____

Office Use Only:
Chart#:_____ Request received: _____ Request completed:_____
Charges $_____ Payment received: _____Initials:_____