PLEASE MAIL RECORDS

expediently so we may offer the patient an earlier appointment should one come available.

Patient, please send this to your providers so they will forward your records to us. Do **NOT** send back to us

HIPAA Compliant Authorization to Release Medical Information

(The execution of this form does not authorize the release of information other than that specifically described below.)

Release From: _____
_____
_____
_____

Patient: _____
Birthdate: _____
SSN: _____

Release To: Dr. Kevin Bachus
1080 E. Elizabeth Street
Fort Collins, CO 80524
NO FAXING PLEASE

I request and authorize the above-named health plan, doctor or health care provider, to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

_____ Drug use, if any
_____ Genetic testing, if any
_____ Alcoholism or alcohol abuse, if any
_____ Sickle Cell Anemia, if any
_____ AIDS/HIV, if any
_____ Substance abuse, if any

INFORMATION REQUESTED:

_____ Copy of history & physical, discharge summary, operative reports, psychological, psychiatric, or other counseling notes

_____ Copy of outpatient & ER admission

_____ X-rays, MRI's and all other imaging studies

_____ Copy of complete medical or hospital chart

DATES COVERED:
_____

_____ All admissions or care at this facility or by this doctor

_____ *Limited to treatment dates & for conditions described below:

* __**INCLUDE ACTUAL HSG FILMS AND REPORT (IF APPLICABLE)**_ These will need to be requested from the **radiology department** where you had procedure done._____

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. This authorization will automatically expire one year from date it is signed unless otherwise specified below. If you desire an earlier expiration date, please fill in the following blank. Expiration date: _____

OTHER CONDITIONS: A copy of the Authorization or my signature thereon: _____may, _____may not be used with the same effectiveness as an original.

HIPAA REQUIRED STATEMENTS:

I UNDERSTAND THAT NON-RESEARCH RELATED TREATMENT MAY NOT BE CONDITIONED UPON SIGNING THIS RELEASE.

I UNDERSTAND THAT THE INFORMATION PROVIDED UNDER THIS RELEASE MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT UNDER CIRCUMSTANCES NO LONGER PROTECTED BY HIPAA PRIVACY RULES.

I UNDERSTAND THAT I MAY REVOKE THIS RELEASE AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN TO COMPLY WITH IT. TO REVOKE THIS AUTHORIZATION, I MUST PROVIDE WRITTEN NOTICE TO THE HEALTH PLAN, DOCTOR, OR HEALTH CARE PROVIDER NAMED IN THIS RELEASE AND WRITTEN NOTICE TO THE ORGANIZATION OR ENTITY TO WHOM I HAVE AUTHORIZED THE RELEASE OF INFORMATION.

_____ MONTH/DAY/YEAR

_____ PRINT OR TYPE NAME

_____ SIGNATURE:

PERSON AUTHORIZED TO SIGN FOR PATIENT:

Relationship to Patient:_____
State how authorized: _____

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