



<b>University of Colorado Hospital</b> Adult Medical Genetics Program 12635 East Montview Boulevard, Suite 124 Aurora, CO 80010 (303) 724-1400 Phone (303) 724-0020 Fax	Medical Record # Patient Name Date of Birth SSN
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**AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION**

OBTAIN FROM: (Releasing facility)			RELEASE TO: (Receiving entity)		
Name			Matthew Taylor, MD		
Address			12635 East Montview Blvd Suite 124		
City State Zip			Aurora CO 80010		
Phone Fax			303-724-1400 303-724-0020		

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by University of Colorado Hospital. I understand that this authorization is voluntary, that further treatment can not be conditioned upon my signing this authorization, and that there may be a cost to copy the records.

**INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY):**

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

<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> Mental Health Treatment	<input type="checkbox"/> Genetic Information
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Drug/Alcohol Treatment	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Operative Report	<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> X-Ray Films-maintained by Radiology Dept
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Laboratory Reports	Other: _____
<input type="checkbox"/> Clinic/Progress Notes	<input type="checkbox"/> Other Test Results:	_____
<input type="checkbox"/> Immunization Records		_____

**INFORMATION IS TO BE USED FOR:**

Continuity of Medical Care       Damage/Claim Information       Personal Use

Other: \_\_\_\_\_

**AUTHORIZATION:** 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 this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy of facsimile of this form is to be considered as valid as the original.

_____ Signature of Patient or Authorized Representative	_____ Date of Signature
_____ Printed Name	_____ Relationship to Patient (if applicable)

**PATIENT'S ACKNOWLEDGEMENT OF ACCESS TO MEDICAL RECORDS**

I hereby acknowledge that I the patient/authorized representative have inspected \_\_\_\_\_ and/or received \_\_\_\_\_ photocopies of the medical records from the University of Colorado Hospital for the above named patient.

_____ Date	_____ Signature	_____ Date	_____ Witness Signature
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