CUSTER COUNTY MEDICAL CENTER

PO Box 120, Westcliffe, CO 81252
Telephone: 719-783-2380 Fax: 719-783-2377

AUTHORIZATION FOR RELEASE/DISCLOSURE/ACCESS OF MEDICAL INFORMATION

Release/Disclose records and information regarding:

_____ _____
Name of Patient **Date of Birth**

Please REQUEST Medical Information FROM:

_____
Name of Provider
_____
Address
_____
City, St, Zip
_____
Telephone and Fax

Please SEND Medical Information TO:

_____
Name of Provider
_____
Address
_____
City, St, Zip
_____
Telephone and Fax

TYPE OF ACCESS REQUESTED: Please

- o **Inspection. Please let me know when I may come to inspect the records, and the amount of the charge. I understand that an employee of this medical practice may be present and that I may not make any marks or alter the records in any way.**
- o **Copies. I would like copies of all records requested.**

DURATION: **This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature if no date entered.**

REVOCATION: **This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.**

REDICLOSURE: **I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.**

SPECIFY **check the circle and initial which type of information is to be released/disclosed:**

- o **Entire Medical Record** **Dates: _____ Init. _____**
- o **Specific Injury or Treatment** **Dates: _____ Init _____**
- o **X-Ray films and reports** **Dates: _____ Init _____**
- o **Laboratory Results** **Dates: _____ Init _____**
- o **Mental Health** **Dates: _____ Init _____**
- o **Alcohol/Drug** **Dates: _____ Init _____**
- o **HIV Test Results**
- o **Other**

RECORD ACCESS: **I WOULD LIKE ACCESS TO:**

- o **All my records OR**
- o **The portion of my records concerning:**

_____
_____
_____
_____

CHARGES:

INSPECTION OF RECORDS: I understand that you may charge me for reasonable clerical costs incurred in making the records available for inspection at a rate of $5.00 per quarter hour and I may be required to pay these costs before I may inspect the records.

COPIES OR TRANSFER: I understand that I will be charged $14.00 for 1st 10 pages. $.50 cents for pages 11-40 and $.33 cents for any additional pages

I hereby authorize the above listed provider to release/disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

SIGNED: _____ Date: _____

PRINT: _____ TELEPHONE_____