Authorization for Medical Release of Information
From the Colorado Psychiatry Center, PC

Patient Name ____ **Date of Birth** ____________________

Address____**City/State/Zip**____________________________________

Phone ___________________________________

Parent/Guardian/Requestor - Completing This Form ____

RELEASE:
I authorize the following to release Medical Record information from Colorado Psychiatry Center to:

PC: Pediatrician/Family Doctor/New Psychiatric Provider:

Name/Practice____

Address/City/State/Zip ____

Phone # _______________________________ Fax # ___________________________

Psychologist/Therapist/Other:

Name/Practice ____

Address/City/State/Zip ____

Phone # _______________________________ Fax # ___________________________

INFORMATION TO RELEASE:
____Medical Records from the Initial evaluation visit and the last 3 visits, including psychotherapy notes, substance use and HIV/AIDS related information. This is the most helpful format for other providers.

Or

____Medical Record for specific Dates: ____________ to ____________, including psychotherapy notes, substance use and HIV/AIDS related information.

Important: Please show valid ID with your records request.

RELEASE MEDICAL INFORMATION FROM:
Colorado Psychiatry Center, PC
11154 Huron St #212
Northglenn, CO 80234
Phone: (303)799-1600 Fax: (303)452-4625

PATIENT/AUTHORIZED REPRESENTATIVE AUTHORIZATION
I understand that: (1) My signature on this form is strictly voluntary.
(2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
(3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations.
(4) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

____ ____________________________________ _________________
Signature Relationship to Patient Date