

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
700 N. Colorado Blvd, Ste 422
Denver, CO 80206
Phone: (303)920-5161

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