Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____

Request and Authorize: _____

Release Information to: Colorado Eye Gallery

☐ **DENVER**	☐ **BROOMFIELD**	☐ **BOULDER**
5026 E. Hampden Ave.	520 Zang St. Ste I	6545 Gunpark Dr. # 250
Denver, CO 80222	Broomfield, CO 80021	Boulder, CO 80301
P 303-756-5900	P 720-887-6066	P 303-530-1973
F 303-756-5902	F 720-887-5866	F 720-638-1223

Purpose of Request: ☐ *Continuation of care* ☐ _____

Information to be Released: ☐ *Clinical records and photos relating to eyecare*

☐ _____

☐ *Most recent visit/encounter* ☐ *All visits/full record*

Request Timeline: ☐ *Standard (five business days)* ☐ *Urgent*

1. I authorize the release of my medical record, including photographs.
2. This authorization is voluntary, and the disclosure is made at my request.
3. If the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
4. Multiple requests are authorized if the purpose of the request remains the same.
5. I have a right to revoke this authorization at any time, and if I revoke this authorization, I must do so in writing and present the written revocation to the department that I have authorized to release the information. Any revocation will not apply to information that has already been released in response to this authorization.
6. I need not sign this form to ensure health care treatment.

This authorization expires 180 days from the date signed below.

_____ _____

Signature of patient or legal representative Date