Peak Primary Care PLLC

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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient's Name: _____
(PLEASE PRINT)
Date of Birth: _____ Social Security Number: _____
Phone Number: (H) _____ (W) _____

Release TO: *Peak Primary Care*
Address: 2200 E 104th Avenue #115
Thornton, Colorado 80233
Phone: (303)452-2766

Release From: _____
Address: _____
_____
Phone: _____

I request and authorize the release of information to the organization, agency, or individual names above. I understand that the information to be released may include the following condition(s):

1. Drug abuse/alcohol abuse (Federal Regulation 42C.F.R., Part 2).
2. Psychological or psychiatric conditions.
3. A test for the presence of antibodies (HIV) virus, which causes AIDS.
4. An AIDS diagnosis and/or an AIDS related condition.
5. Any third party source (i.e. Hospital, specialist office, laboratory).

Information requested (please initial all items you authorize to be released):

_____ Medication List _____ Problem List _____ Immunization Records

_____ Colonoscopy _____ Mammogram _____ DEXA

_____ Other

Treatment date(s): _____
Purpose of Release: _____

I certify that this request has been made voluntarily. This authorization is subject to written revocation at any time, except to the extent that action has already been taken to comply with in. In any event, this authorization expires ninety (90) days from the date of signature. I release the above names from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.

_____ _____
(Date) (Signature of Patient)

_____ _____
(Witness) (Signature of Legal Guardian/Executor)

If patient unable to sign, please document reason: _____

NOTE: *Information requested will not be provided if any of the above items have not been completed*. According to Colorado State Statues, there is a charge for copies of medical records. The charge is $12.00 for 1-10 pages and $0.25/page thereafter.