Aspen Family Care

Medical Record Release Form

9331 S. Colorado Blvd, Suite 200, Highlands Ranch, CO 80126
Phone 303.471.4711 ▪ Fax 303.471.4767

Authorization to Use or Disclose My Health Information

Patient name:_____DOB:_____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

- ○ **No Charge –** All my health information maintained by the above-named practice for the **last 2 years.** I understand that this may include records relating to drug abuse, alcohol abuse, HIV/AIDS, psychological/psychiatric conditions including psychotherapy notes.
- ○ **No Charge** – Records related to one date of service – Date of service requested: _____
- ○ **No Charge – Thumb drive:** All my health information maintained by the above-named practice. I understand that this may include records relating to drug abuse, alcohol abuse, HIV/AIDS, psychological/psychiatric conditions including psychotherapy notes.
- ○ **$15 – Paper records less than 200 pages:** All my health information maintained by the above-named practice. I understand that this may include records relating to drug abuse, alcohol abuse, HIV/AIDS, psychological/psychiatric conditions including psychotherapy notes.
- ○ **$25 – Paper records 201+ pages:** All my health information maintained by the above-named practice. I understand that this may include records relating to drug abuse, alcohol abuse, HIV/AIDS, psychological/psychiatric conditions including psychotherapy notes.

Release Records

○ **To**
○ **From**

Aspen Family Care
9331 S Colorado Blvd Ste 200
Highlands Ranch CO 80126
Phone: 303.471.4711
Fax: 303.471.4767

○ **To**
○ **From**

_____
Name/Organization
_____
Address
_____
City State Zip
_____
Phone Fax

Reason(s) for this authorization (check all that apply):

- ○ At my request
- ○ Transferring care
- ○ Other:

II. My Rights

I understand I do not have to sign this authorization form in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study **OR** to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office **OR** Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. This authorization will remain valid for one year from the date of my signature.

_____ _____
Patient or legally authorized individual signature **Date**