Rocky Mountain Movement Disorders Center, P.C.

701 E. Hampden Ave Ste 510 Englewood CO 80113
Phone (303) 357-5455 Fax (303) 357-5459

AUTHORIZATION FOR RECORDS RELEASE

Patient Name: _____ D.O.B.: _____

Patient Address: _____ Phone #: _____

Driver's License/State Issued ID #: _____

☐ **To release records to another provider:** I authorize Rocky Mountain Movement Disorders Center, P.C., to disclose my protected health information to:

Recipient's name: _____

Address: _____

Phone: _____ Fax: _____

☐ **To obtain outside records:** I authorize the entity listed below to disclose my protected health information to Rocky Mountain Movement Disorders Center, P.C.

Requesting records from (name): _____

Address: _____

Phone: _____ Fax: _____

I authorize the following information to be released:

☐ Please release ALL medical records

☐ Specific dates of service only - From: _____ To: _____

☐ Request for specific documents:

☐ MRI Reports	☐ Progress Notes	☐ CT Reports
☐ MRI CD	☐ Lab Reports	☐ CT Scan
☐ DaT Scan	☐ X-Ray Reports	☐ EMG Report
☐ DaT Scan Report		

_____ Initials I acknowledge, and hereby consent to such, that the released information may contain information relating to mental health/psychiatric records, alcohol/drug abuse records, and/or records relating to HIV/AIDS/Sexually transmitted diseases (including test results).

The purpose of the release of this information is (please check all that apply):

☐ Continuity of medical care
☐ Clinical research trials
☐ At the request of patient
☐ Other (please specify): _____

This authorization will expire on (date): _____. If left blank, then this Authorization will expire 1 year from the signature date stated below.

I understand that:

I may refuse to sign this Authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I may request to inspect or obtain a copy of the health information being released pursuant to this form for a reasonable copy fee.

I may revoke this authorization at any time, by sending a written notification to RMMDC's Privacy Officer at: 701. E. Hampden Ave., Suite 510, Englewood, CO 80113. If I choose to revoke this authorization, I understand that my written revocation will not have any effect on actions taken prior to our receipt of the revocation.

My protected health information being released pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy regulations.

I am entitled to receive a copy of this form after I sign it.

Signature of Patient or Patient's Representative Date

Please print name & relationship to the patient Date