Authorization for Medical Release of Information
From and To the Colorado Psychiatry Center, PC

Patient Name _____ **Date of Birth** _____

Address_____**City/State/Zip**_____

Phone _____

Parent/Guardian/Requestor Completing This Form _____

RELEASE FROM and TO:
I authorize the following to release Medical Record information to Colorado Psychiatry Center, PC:
Pediatrician/Family Doctor:

Name/Practice_____

Address/City/State/Zip _____

Phone _____ Fax _____

Psychologist/Therapist/Other:

Name _____

Address/City/State/Zip _____

Phone _____ Fax _____

Individuals that I authorize to attend appointments with the patient when I am not available:

Name _____Relationship to patient_____

Name _____Relationship to patient_____

Name _____Relationship to patient_____

INFORMATION TO RELEASE
____Complete Medical Record, including psychotherapy notes, substance use and HIV/AIDS related information
____Medical Record for Dates: _____ to _____, including psychotherapy notes, substance use and HIV/AIDS related information

Important: If we are communicating with other caregivers, we will send the initial evaluation and last three visits unless you ask us to do otherwise. This is usually the most helpful format for other providers. Please show valid ID with your records request.

RELEASE MEDICAL INFORMATION FROM and TO:

Colorado Psychiatry Center, PC
88 Inverness Circle E, Ste J-106
Englewood, CO 80112
Phone: (303)799-1600 Fax: (303)452-4625

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, but in any event will expire 365 days from the date hereof.

_____ _____ _____
Signature Relationship to Patient Date