



Authorization to Disclose Protected Health Information
The undersigned authorizes

Colorado Springs Urological Associates
1644 Medical Center Point Ste 200 Colorado Springs, CO 80907
(P) (858) 244-1811 (F) (866)-650-0595

to release my health information as noted below:

Patient Information

Patient Full Name: _____ Other Names? _____

Patient Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

If email delivery is preferred, you must provide a valid email address of either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email or mail.

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax #: _____

Purpose of Request: Personal Treatment Legal Insurance Transfer Other: _____

Information to be Released

If you fail to specify, a 1-year abstract will be provided.

<p>___ Please release a 1-year abstract of my records (includes most recent notes, labs, procedures & testing)</p> <p>___ Please release a 2-year abstract of my records (office notes, labs, procedures & testing, up to 2 years)</p> <p>Date Range: _____ :</p> <p><input type="checkbox"/> Progress Notes <input type="checkbox"/> Radiology Reports <input type="checkbox"/> Labs</p> <p><input type="checkbox"/> Operative Reports <input type="checkbox"/> Injections <input type="checkbox"/> Physical Therapy</p> <p><input type="checkbox"/> Other: _____</p>	<p>(Please pick ONE delivery option)</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 33%; text-align: center; padding: 5px;"><input type="checkbox"/> Send by Email</td> <td style="width: 33%; text-align: center; padding: 5px;"><input type="checkbox"/> Fax to Doctor</td> <td style="width: 33%; text-align: center; padding: 5px;"><input type="checkbox"/> Records on Paper</td> </tr> <tr> <td style="text-align: center; padding: 5px;"><input type="checkbox"/> Records on CD</td> <td colspan="2"></td> </tr> </table> <p style="text-align: right; margin-top: 10px;">Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Colorado Statute: <i>(Rule 18-Medical Fee Schedule 18-6)</i></p>	<input type="checkbox"/> Send by Email	<input type="checkbox"/> Fax to Doctor	<input type="checkbox"/> Records on Paper	<input type="checkbox"/> Records on CD		
<input type="checkbox"/> Send by Email	<input type="checkbox"/> Fax to Doctor	<input type="checkbox"/> Records on Paper					
<input type="checkbox"/> Records on CD							

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____ (Please Initial)

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____ *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.



Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released; we may be unable to fulfill this request.

Signature*: _____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*