Medical Records Request Form

***** PLEASE NOTE: IF THIS FORM IS NOT COMPLETED IN FULL, IT WILL DELAY THE TIMING OF THIS REQUEST *****

Patient Name: _____ Date of Birth: _____ Primary Contact Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

For the purpose of: ☐ Continuing care/treatment ☐ Legal ☐ Personal Use ☐ Insurance ☐ Other _____

I hereby authorize my release of protected health information as described below, **TO / FROM** (Circle One)**:**

☐ SELF **OR** ☐ Name of Individual/Organization: _____

Address: _____ Phone: _____ Fax: _____

Requested Format: ☐ Paper ☐ USB/Flash Drive (*additional* $5.00 fee *for imaging/testing)*

Delivery Method: ☐ Mail: _____

Address, City, State, Zip

☐ Email: _____ ***NOTE:*** *Unencrypted email is* ***not protected*** *from unauthorized access by unknown third parties once it leaves Eye Care Center of Northern Colorado electronic systems, and may be subject to unauthorized use or disclosure. All emails will be sent* ***encrypted*** *unless you specifically request they not be by checking this box:* ☐

☐ Fax: _____ Attention to: _____

☐ Pick up from Eye Care Center

Type of Access Requested: ☐ Complete Chart ☐ Imaging/Testing ☐ Billing/Itemized Records ☐ Other _____

For the time period _____/_____/_____ to _____/_____/_____

THIS REQUEST WILL BE COMPLETED WITHIN 10 BUSINESS DAYS unless requested by a physician. Please specify below:

** Records needed ASAP. Patient has an appointment on: _____/_____/_____.

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results, or AIDS information. I understand that this authorization may be revoked by me at any time except to the extent that action has already been taken in reliance upon it. The information or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that there may be a fee involved with the fulfillment of this request (See the fee schedule below). I understand that the term "complete chart" for release of protected health information means that only records generated by this facility will be released. I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Parent/Legal Guardian: _____ Date: _____

Per State of Colorado (CO) Medical Record Fee Schedule House Bill 14-1186: First 10 pages or fewer will incur a flat fee of $18.53; Pages 11-40 will incur a fee of $0.85 per page; Pages 41+ will incur a fee of $0.57 per page. Postage fee will include actual cost of mailing.

eye CARE center of northern colorado, pc

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