Please allow 5-10 business days for processing

PRIMARY CARE PARTNERS

Records Release Authorization

Medical records | P: (970) 256-5240 | F: (970) 778-3136

3150 N. 12th Street • Grand Junction, Colorado 81506
P.O. Box 10700 • Grand Junction, Colorado 81502

FAXED OR MAILED RECORDS RELEASE SHOULD BE ACCOMPANIED BY PICTURE ID (OR THAT OF A PARENT/GUARDIAN) & WITNESS SIGNATURE

I give permission to Primary Care Partners to: (check one)

- ☐ **Obtain (get) information from:**
- ☐ **Release (give) information to:**
- ☐ **Exchange (share) information with:**

Who are we getting records from or sending records to?

Name:_____

Address:_____

_____

Phone: _____ **Fax:** _____

This authorizes the release of the requested information on the individual(s) below:

(One patient per line. If additional space is needed, please use back of form)

Patient Name:_____ **DOB:**_____

Patient Name#2:_____ **DOB:**_____

Information Format: ☐ **Mail** ☐ **Pick Up** ☐ **Fax** ☐ **Email** *enter below* _____ ☐ **USB drive**

Information Requested:

- ☐ **Standard Records (last 3 yrs. office visits, physicals, growth charts, vaccines, problem list, laboratory results, radiology reports, hospital notes)**
- ☐ **Limited records (events, dates:**_____**)**
- ☐ **Complete Records**
- ☐ **Immunization Records**
- ☐ **Psychotherapy Notes**
- ☐ **Radiology *IMAGES* on disc (date:**_____**)**

Primary Care Partners can only provide images for tests we have conducted. For radiology done by a third party, please request the images directly from them.

I request and authorize the above named provider/s to release this information. I understand the records may include information regarding the following conditions: drug or alcohol abuse, psychological or psychiatric conditions, developmental disabilities, sexually transmitted diseases, pregnancy or other sensitive information.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. I understand the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____ (if nothing is entered, expiration will be **1 year** from date signed).

First copies are at no charge. I understand that I may be charged a reasonable fee per rates set by the Colorado State Board of Health after the first courtesy release for: paper copies or transfer, electronic records, or mailing (including postage/materials).

I hereby agree to pay the charges specified above: ☐ Please bill me. ☐ Please contact me with total incurred cost.

I understand that HIPAA allows up to 30 days to process my request for records.

Print Name:_____ **Relationship:**_____

Signature:_____ **Date:**_____

Witness Signature:_____ **Date:**_____