

Boulder Valley Asthma & Allergy Clinics, P.C

1746 Cole Blvd
Lakewood, CO 80401

Phone: 303-234-1067
Fax: 303-232-2967

REQUEST FOR RELEASE OF MEDICAL RECORDS

I authorize the disclosure of health information for the individual named below:

Patient Legal Name: _____ Date of Birth: _____

Address: _____ Phone number: _____

Description of information that may be used/disclosed:

- Medication list
- Problem list
- Evaluation and Treatment Reports
- Consultation Reports o Most Recent 3 years
- Entire Medical Record
- Actual Skin Test Results (copy of testing sheet preferred)
- Actual Recipe of Treatment Extract & Injection Record
- Laboratory Results, from date _____ to date _____
- X-ray Reports, from date _____ to date _____
- Other _____

This information may be disclosed to and used by the following individual or organization:

Records are requested:

to be disclosed:

To
From

To
From

Boulder Valley Asthma & Allergy Clinics, P.C.
1746 Cole Blvd #320
Lakewood, CO 80401
303-234-1067 (Office)
303-232-2967 (Fax)

(Include name, complete fax & phone numbers)

I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever comes first.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I

understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

I understand authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment in the health plan or eligibility for benefits may not be conditioned on the signing of an authorization, except as otherwise permitted by law.

I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information used/disclosed carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Our Privacy Practices provides more detailed information abut how we may use and disclose this protected health information. You have the legal right to review our notice of Privacy Practices before you sign this consent, and we encourage you to read in full.

Patient/Parent Signature

Date