Boulder Valley Asthma & Allergy Clinics, P.C.

1746 Cole Blvd Suite 320
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	☐ Actual Skin Testing Results (copy of testing sheet preferred)
☐ Problem List	☐ Actual Recipe of Treatment Extract & Injection Record
☐ Evaluation and Treatment Reports	☐ Laboratory Results, from date_________ to date_________
☐ Consultation Reports ☐ Most Recent 3 Years	☐ X-ray Reports, from date_________ to date_________
☐ Entire Medical Record	☐ Other______________________________

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

Records are requested:

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

To be disclosed:

☐ To or ☐ From (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 about 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 or Guardian Signature)

____
(Date)