

****Incoming Records Release****

Colorado West Otolaryngologists, PC

2643 Patterson Rd, Suite 503 ♦ Grand Junction, CO 81506
970-245-2400 ♦ Fax 970-242-9092

TO:

PATIENT IDENTIFICATION:

Name

Name

Address

Last 4 digits SS#

City/State/Zip

Birth Date

GENERAL AUTHORIZATION: I hereby request that my medical records be released to Colorado West Otolaryngologists, P.C., 425 Patterson, Suite 503, Grand Junction, CO 81506. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed.

SPECIFIC AUTHORIZATION: () Please initial. Specifically authorize the release of the following information.

- Alcohol and/or Drug Abuse, if any
- HIV/AIDS Status, if any
- Psychological or psychiatric conditions, if any

INFORMATION REQUESTED:

- Copies of hospital History & Physical, Discharge Summary, Operative Reports
- Copies of imaging studies
- Copies of office visits
- Copies of audiograms
- Copy of complete chart
- Other
(specify): _____

This authorization ends: on _____ (no longer than 1 year from date signed)
 When the following event occurs _____

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. A copy of this authorization may be utilized with the same effectiveness as an original.

Signature of Patient or Parent/Legally
Authorized Person

Printed Name of Patient or Parent/Legally
Authorized Person

Date

How authorized