

****Outgoing Records Release****

Colorado West Otolaryngologists, PC

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

PATIENT IDENTIFICATION:

RELEASE TO:

Name

Name

Last 4 digits SS#

Address

Birth Date

City/State/Zip

GENERAL AUTHORIZATION: I hereby request and authorize Colorado West Otolaryngologists, P.C. to release my medical records to the above named. I understand that release of this information will no longer guarantee the confidentiality of the information disclosed. I release Colorado West Otolaryngologists, P.C, my physician and all CWO personnel from any and all liability concerning disclosure of this information.

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
- Verbal medical/billing information
- 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. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Signature of Patient or Parent/Legally
Authorized Person

Printed Name of Patient or Parent/Legally
Authorized Person

Date

How authorized

Records released by: _____ Date: _____

Records picked up mailed faxed