Outgoing Records Release
Colorado West Otolaryngologists, PC

2515 Foresight Cir, Ste 200
Grand Junction, CO 81505
970-245-2400
Fax 970-242-9092

100 Tessitore Ct. Ste B
Montrose, CO 81401
970-787-4710
Fax 970-615-7007

233 Cottonwood St
Delta, CO 81416
970-245-2400
Fax 970-242-9092

711 N Taylor St
Gunnison, CO 81230
970-787-4710
Fax 970-615-7007

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient's name _____ Date of Birth _____

Previous or AKA name _____

MY AUTHORIZATION

I authorize Colorado West Otolaryngologists, PC to disclose my specified health information to the following individual(s) in person, by mail or by fax as described and directed below.

- ☐ Pick up
- ☐ Mail
- ☐ Fax

Individual(s) authorized to have my specified health information disclosed to them:

Name _____ Phone # _____

Address_____ Fax _____

City/State/Zip _____

Information that Colorado West Otolaryngologists, PC may disclose:

- Billing information
- All Health Care Information
- Office Visits
- Audiograms
- Operative Reports
- Imaging Studies
- Sleep Studies
- Other (Specify) _____
- All Health Care Information EXCEPT the following excluded information:
  - Do not share information related to psychological or psychiatric conditions.
  - Do not share information related to drug abuse/alcohol abuse.
  - Do not share information related to HIV/AIDS
  - Do not share information related to: _____

This Authorization is valid for 1 year or ❑ _____

Date

ACKNOWLEDGEMENT

I understand by completing this form, I am giving authorization to the above-stated person(s) to receive health information from my medical chart. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I release Colorado West Otolaryngologists, PC, from all liability concerning disclosure of this information.

I understand that this authorization is at my request, and I may revoke or change my request at any time in writing. If I do, it will not affect any actions already taken by the above-named person(s) or by Colorado West Otolaryngologists, PC based upon the authorization.
By signing below, I acknowledge that I have read and understand the above information.

_____ _____ _____

Signature of Patient/Guardian Print Name Date

Records Released by:_____ date: _____