Incoming

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
970-245-2400Fax 970-242-9092

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

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Requesting information from:

_____

Name of facility

_____

Address City/State/Zip

_____

Phone Fax

Patient information:

_____ _____

Patient name Date of Birth

MY AUTHORIZATION

I hereby request that my medical records be released to:

Colorado West Otolaryngologists, PC _____ (enter location)
Please fax if possible to _____ (enter fax for correct location).

Information to by disclose:

- ❑ 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 is valid for 1 year or ❑ _____
Date

ACKNOWLEDGEMENT

I understand that the release of this information will no longer guarantee the confidentiality of the information disclosed. I understand that this authorization is at my request, and I may revoke or change my request at any time in writing.

By signing below, I acknowledge that I have read and understand the above information.

_____ _____

Signature of Patient/Guardian Date

_____

Printed name

This form was: Faxed _____ Mailed _____