



# Youth Clinic

1200 E Elizabeth Street ~ Fort Collins, CO 80524 ~ Ph 970.416.6293 ~ Fax 970.416.6299

## Authorization for Release of Information

Patient Name \_\_\_\_\_

LAST                      FIRST                      MI                      MAIDEN / OTHER NAME

Date of Birth \_\_\_\_\_ Medical Record # \_\_\_\_\_  
(Office Use Only)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

***I hereby authorize the release of medical records as indicated below:***

Released <b>from:</b>	Released <b>to:</b>
Name _____	Name _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____
Fax _____	Fax _____

***Information to be released***

- History and physical exam
- Progress notes
- Lab reports
- X-ray reports
- Other: \_\_\_\_\_

***Dates requested***

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

***ONLY THE PAST 5 YEARS OF RECORDS ARE PROVIDED UNLESS OTHERWISE REQUESTED***

I specifically authorize the release of information relating to:

- Substance abuse (including drug and alcohol abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian                      Date

***Purpose of Disclosure***

Is patient transferring out of the practice \_\_\_\_\_ Yes    \_\_\_\_\_ No

If **yes**, please indicate the reason

- Change of insurance                      Name of new insurance carrier \_\_\_\_\_
- Moving out of area
- Family consolidation
- Aged out
- Unhappy with care of service

If **no**, please indicate the reason

- Specialist                       Legal
- Consultation / second opinion                       Insurance request
- Personal use                       Verbal exchange only
- Other (please specify) \_\_\_\_\_

***PLEASE NOTE - A fee will be charged for records copied for legal, personal and insurance company requests.***  
*(continued)*

**I understand the following:**

1. This authorization will expire one year after the date this form is signed.
2. I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified, except to the extent action has already been taken in reliance upon it.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by Federal privacy regulations.
4. I am being requested to release this information by \_\_\_\_\_ (print name of provider) for the purpose of:  

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  - a. By authorizing this release of information, my health care and payment for my healthcare will not be affected if I do not sign this form.
  - b. I understand I may see and copy this information described in this form if I ask for it and that I will get a copy of this form after I sign it.
  - c. I have been informed that \_\_\_\_\_ (print provider name)  will  will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. Compliance with Colorado statute, I will pay a fee of \$ \_\_\_\_\_ (print fee charged). There is no charge for medical records if copies are sent to the facilities for ongoing care or follow up treatment.

**\*\*INCOMING RECORDS ONLY\*\***

**Your provider will review these records and the contents felt to be clinically useful will be scanned to your electronic health record. It is impractical for FCYC to store or scan the entire file. We encourage you to keep these records for your own files and future needs. Please select one of the following options. Option A is recommended.**

\_\_\_\_ **A. After selective parts of the transferred record are scanned to the electronic health record, I agree to pick these up within 30 days, after being notified, and retain for my own records.**

\_\_\_\_ **B. After Selective parts of the transferred record are scanned to the electronic health record, I give my permission for FCYC to shred the entire copy of the record.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Records Received By

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

**FOR OFFICE USE ONLY**

Date Request Filed \_\_\_\_\_

By \_\_\_\_\_

Identification Presented \_\_\_\_\_

Fee Collected \_\_\_\_\_