Southside
1120 Minnequa
Pueblo, CO 81004
Office 564-0660
Fax 564-0037

Northside
1600 N. Grand, Ste 260
Pueblo, CO 81003
Office 543-6755
Fax 583-2236

Associates in Women's Health Care

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS

Please make a copy for your records.
There will be a fee for additional copies.

1. Regarding Patient

Name - Last, First, MI		Other Names Used
Street Address		Phone #
City		Cell #
State	Zip Code	Birthdate

2. Records Released From

Name - (i.e. Health Facility, Physician . .)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

3. Records Released To

Name - (i.e. Health Facility, Physician . .)		
Street Address		
City	State	Zip Code
Phone #	Fax #	

❑ These records are needed for an appointment on _____

❑ I would like to pick up copies, call me when ready.

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information and/or records, if such information and/or records exist:

All medical records _____ (initial).

Only some portion of records maintained at facility, check below _____ (initial).
_____ Lab _____ Prenatal _____ Chart Notes _____ Pathology _____ X-ray _____ Other (specify) _____

Sensitive information. The following items must be initialed to be included in the use or disclosure of other health information.

Initials
_____ Drug abuse, if any
_____ Psychological or psychiatric conditions, if any
_____ Abortion
_____ Sickle Cell Anemia

Initials
_____ Substance abuse, if any
_____ AIDS/HIV, if any
_____ Sexually transmitted diseases
_____ Other _____

Except to the extent that information has already been released, I understand that I may revoke this authorization at any time by giving written notice. Unless revoked earlier, this authorization will expire 180 days from the date of the signing.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization. I also understand that if the person or entity receiving this information is not a health care provider or a health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

_____ _____
Signature of Individual or Individual's Legal Representative/Relationship Date

Release Date: _____ #Pgs _____ Certified: Y N Via: Mail Fax Pick up Completed by Initials _____