COLORADO ALLERGY & ASTHMA CENTERS, P.C.

Breathe Better - Live Better!

Medical Record Release of
Protected Health Information (PHI) From CAAC

I authorize the use/disclosure of health information about ____________________________________
(Patient Name and date of birth)

as described below:

1. Name and address of party to receive information:

   ____

   ____

2. Description of information that may be used/disclosed (Be specific – either entire health record (chart) or specific parts i.e. visit notes, testing results, lab results, dictations etc.

   ____

3. The information will be used/disclosed for the following purposes: Check one
   ☐ Transfer of care ☐ Insurance company review
   ☐ Other – specify ____

4. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization.
   This authorization expires on _____________________. **(Must be filled in)**
   (Date) day/month/year **Expiration date is for no greater than a year**

7. I understand there may be a reasonable fee applied for records copied.

____ ____________________________

Signature of Patient or Representative Date

____ ____________________________

Patient's Name (print) Date of Birth