at UC Health Harmony Campus
2121 E. Harmony Rd., Suite 350A
Fort Collins, CO 80528
Phone # (970) 214-8175
Fax # (970) 788-7376

MEDICAL RECORDS RELEASE FORM

Authorization to Use or Disclose Patient Health Information

Patient Name (First / Middle Initial / Last):

____

Patient Date of Birth (MM/DD/YY): _________________________

Gender (circle one): Female Male Non-binary Prefer not to say

PATIENT AUTHORIZATION

You may use or disclose the following health care information (check all that apply)

☐	All patient health information maintained at the above practice (circle exclusions below if any)
☐	Patient health information related to the following treatment __________________________________
☐	Patient health information for the following date(s) _______________________________________
☐	Other ____

You may disclose patient health information to (Person's or Organization's Name):

____

Mailing Address:

____

City: ______________________________________ **State:** ___________ **Zip Code:** _________________

Phone Number: ______________________________________ **Fax Number:** ______________________________________

Reason(s) for this authorization (check all that apply):

☐	Transferring care to another office
☐	At the patients request
☐	Other ____

This authorization ends (MM/DD/YYYY)____

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PATIENT RIGHTS

The patient understands they or their parent or guardian does not have to sign this authorization to receive health care benefits (treatment, payment or enrollment).

The patient may revoke this authorization in writing. If they do, it will not affect any actions already taken by Children's Eye Care of Northern Colorado, P.C. based on this authorization. The patient may not be able to revoke this authorization if the purpose was to obtain health insurance.

Once the patient's health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

___________________________	______________	______________
Patient or Legal Guardian Signature	**Date (MM/DD/YYYY)**	**Time**

___________________________	___________________________
Printed Name (if Legal Guardian)	**Relationship to Patient**