Colorado Springs Ear Associates

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Adult & Pediatric Ear Care Hearing Aid & Cochlear Implant Center
Balance Disorders Center Skull Base Surgery Center

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Release of Medical Records Form

Last Name _____ First Name _____ Middle Initial _____

Date of Birth: _____ Social Security # _____ - _____ - _____

Phone Number (_____)_____ Today's Date _____

I hereby authorize disclosure of my protected health information as follows: (Check all that apply)

_____ Complete Medical Record for all services to include: History and Physical Exam, Progress Notes, Laboratory Tests, X-ray Reports, Audiograms, ENGs, Balance Tests, Special Audiometric Testing.

_____ Hearing Tests Only.

_____ Records related only to the following dates of service _____.

The purpose of this release of information is for:

_____ Transfer of Records to another provider

_____ Attorney

_____ Personal Use

_____ Other (Describe)_____

Name & Address of person(s) to receive Medical Records:

Name _____ Name _____

Address _____ Address _____

City, Zip _____ City, Zip _____

Fax # _____ Fax # _____

I understand the following (Please read and initial all statements):

_____I understand that my records are protected under HIPPA regulations.

_____I understand that under the Federal Protected Health Information regulations, I have the right to review my record and request amendments where appropriate.

_____I understand that there is a fee for copying medical records (according to Colorado law, 6 C.C.R. 1011-1, Chapter 2, Part 5.2.3.4, $16.50/first 10 pgs, $.75/pg for pages 11-40 and $.50/pg for every additional page).

. _____I understand that I may revoke this authorization at any time by notifying Colorado Springs Ear Associates in writing except that revocation will not cancel any action already taken by Colorado Springs Ear Associates.

_____I understand that this Authorization of Release will expire in 90 days from the date signed.

_____ _____

Patient Signature Date