

Better Health, DC, MD. Medical Records Release Form
680 West 121st Avenue, Suite 100, Westminster, CO 80234
Phone: 303-450-9970 Fax: 303-254-9590

Release Medical Records From:

Doctor/Hospital

Street Address

City, State, Zip Code

Phone Number

Fax Number

Send Medical Records To:

Better Health, DC, MD.

Name of Company/Agency/Facility/Person

680 West 121st Avenue, Ste 100

Street Address

Westminster, CO 80234

City, State, Zip Code

303-450-9970

Phone Number

303-254-9590

Fax Number

Patient Information:

Print Patient's Full Name

Date of Birth (Month/Day/Year)

Street Address

Social Security Number

City, State, Zip Code

Daytime Phone Number

Information to be Released:

_____ **I Do** _____ **I Do Not** authorize the release of information related to **HIV / AIDS, psychological or psychiatric conditions**, and treatment for **alcohol and/or drug abuse**.

Release the following records:

_____ 3 years medical records including progress notes and diagnostic results.

_____ Only some portion of records _____.

_____ I choose staff to determine and select pertinent records for transfer.

_____ Other _____.

Purpose of Disclosure:

_____ Referral to Specialist

_____ Permanent Transfer

_____ Personal

_____ Insurance

_____ Workers Comp

_____ Legal Investigation

_____ Disability Determination

_____ Other

There will be a charge for a personal copy of your records.

We will be happy to provide this service and will invoice you directly.

The fee schedule is: 1-40 @ 50¢ ea., 41-100 @ 33¢ ea., 101+ @ 15¢ ea., plus postage

This authorization is valid for 1 year from date of signature unless otherwise indicated: _____

Patient Rights: I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form: *To take part in a research study. *To receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: *Fill out a revocation form or written communication to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it.. Privacy laws may no longer protect it.

Patient or legally authorized individual signature

Date

Printed name of patient of person signing on behalf of patient

Relationship (self/parent/legal guardian/personal representative)