COLORADO SPRINGS
EAR ASSOCIATES

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

Release of Medical Records Form

Last Name _____ First Name _____ Middle Initial _____

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

Phone Number (_____)_____

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 and Fax 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 HIPAA 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, $14/first 10 pgs, $.50/pg for pages 11-40 and $.33/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