

**Joseph L. Hegarty, M.D.**

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 _____
<b>Fax #</b> _____	<b>Fax #</b> _____

**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