REQUEST FOR RELEASE OF MEDICAL RECORDS

Please print legibly

Patient: _____ Date of birth: _____/_____/_____

Address: _____ Phone: _____

_____

I request that my medical records in the possession of _____ be released to:

❑ Dr. Gregory A. Hogle

Mail to Address: 4600 Hale Parkway, Suite 450, Denver, CO 80220

OR

Fax to #: 303-333-2016 Phone #: 303-333-2119

Information to be Released:

- ❑ All records
- ❑ Hearing test(s)
- ❑ Clinic Notes
- ❑ Imaging Reports
- ❑ Pathology Reports
- ❑ Other:_____

Dates of Treatment:

- ❑ All
- ❑ Specific Dates: _____

1. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records indicated above.
2. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. .
3. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
4. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
5. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

_____ _____

Patient, Parent of Minor Patient, or Legal Guardian Signature Date

_____ _____

Signature of Witness Date