COLORADO SPRINGS EAR ASSOCIATES

CASTLE ROCK EAR ASSOCIATES

Release of Medical Records Form

Last Name _____ First Name _____ Birth date _____

Address _____ City/State _____ Zip _____

Phone _____ Email _____

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

☐ Colorado Springs/Castle Rock Ear Associates Medical Records
☐ Hearing Tests Only
☐ Dates of service(s) _____

The purpose of this release of information is for:

☐ Transfer of records to another provider
☐ Legal
☐ Personal Use
☐ Other (Describe)_____

Name, Address, Fax and Email of person to receive Medical Records:

Name _____ Address _____

City, Zip _____ Fax # _____

Email _____

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

_____ I authorize the release of my medical records.
_____ This authorization is voluntary and the disclosure is made at my request.
_____ If the organization authorized to receive the information is not a health care provider, the released information may no longer be protected by federal privacy regulations.
_____ I understand that I may revoke this authorization at any time by notifying Colorado Springs/Castle Rock Ear Associates in writing, except that revocation will not cancel any action already taken by Colorado Springs/Castle Rock Ear Associates.
_____ I understand that this Authorization of Release will expire in 90 days from the date signed and covers only treatment for the date(s) specified above.
_____ I am aware that fees (outlined below) will apply. These fees/charges comply with all laws and regulations applicable to the release of protected health information. Please **select** the option you prefer below and an invoice will be emailed to you. Standard fees are as follows:

- ☐ **Electronic (email) delivery to patient**: $6.50 for all pages
- ☐ **Printed copies picked up in office**: $18.53 (pages 1-10) **plus** $0.85 per page (pages 11-40) **plus** $0.57 per page (each page over 40)
- ☐ **Printed copies delivered to patient**: $18.53 (pages 1-10) **plus** $0.85 per page (pages 11-40) **plus** $0.57 per page (each page over 40) **plus** UPS 2 day secured signature guaranteed delivery (cost will be included in your invoice)
- ☐ **Fax delivery to your medical provider**: **$0**

Please email this completed form to: **contact@springsear.com**. Alternatively, you can fax this completed form to **719-667-1328**.

Once payment is received, medical records will be available to pick up or forwarded to you or your chosen recipient within 20 business days. Please note that health insurance does not pay this fee. If you do not provide your corresponding email, a paper invoice fee will also apply.

_____ _____

Patient Signature Date

IMPORTANT WARNING: The documents accompanying this message are intended for the use of the person or entity which this message is addressed. These documents may contain information this is privileged and confidential, the disclosure of which is governed by applicable law. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. If you are the employee or agent responsible to deliver this information to the intended recipient, you are notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**.