Transfer of Medical Records

PATIENT INFORMATION – PLEASE PRINT

Name: ____

Date of Birth: ________________________________

Phone Number: ________________________________

RELEASE FROM:
Name: ____________________________
Address: __________________________
____
Phone: ____________________________
Fax: ______________________________

RELEASE TO:
Name: ________________________________
Address: ______________________________
____
Phone: ________________________________
Fax: __________________________________

I request and authorize this transfer and release of my medical record to and from the medical practices listed above. I understand that this documentation includes all forms of Protected Health Information (PHI) and is also applicable to the electronic transfer of records if the requested recipient is able to accept and access encrypted information from the New West Physicians Electronic Medical Record.

- ☐ **ENTIRE RECORD - OR:**
- ☐ **Doctor's Notes**
- ☐ **Pathology Reports**
- ☐ **X-Ray Reports**
- ☐ **Laboratory Reports**
- ☐ **Diagnostic Studies**
- ☐ **Third Party Record**
- ☐ **Medications**
- ☐ **Diagnoses**
- ☐ **Other**_______________

Due to the sensitivity of the following information please check off and initial if you would like the following information to be released:

- ☐ Notes and reports related to STDs including HIV/AIDS ________ (initial)
- ☐ Psychiatry/Mental Health Notes ________ (initial)
- ☐ Notes related to Drug/Alcohol Abuse ________ (initial)

I understand that New West Physicians will no longer be responsible for the protection of the PHI except in its original format in their records. The recipient of the medical records becomes responsible for the protection of the PHI once the transfer takes place.
I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present the written revocation to the Site Practice Manager. 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. I certify that this request has been made voluntarily.

(Please Note: There may be a charge for the copying of records)

In Accordance with Chapter 2, Part 5, sections 5.2.3.4 of the Colorado Regulations of Health Facilities, the cost of this information cannot exceed $16.50 for the first 10 or fewer pages and $.75 per page for pages 11 through 40, and $.50 per page after 40 pages. Actual postage or shipping costs and applicable sales tax, if any, may be charged. We will not be able to process your request until the following payment is received.

______________________________ ______________________________
Signature of patient Date

______________________________ ______________________________
Witness

____
Signature of Authorized Representative (If patient is a minor or unable to sign) – Attach Copy of Durable Power of Attorney if patient is an adult

Revised: 2/2016 MM