Medical Records Release

***All information below must be completed in its entirety.

Patient Name____Patient Date of Birth_______________________________________

Patient Medical Record Number____________ Patient Address____

Patient Phone Number____ Today's Date/Date of Request_____________________________

Release Medical Records **From** Asthma and Allergy Associates PC (AACOS) **to**

Doctor/Practice Name____

Doctor/Practice Address____

Doctor/Practice Phone Number____

Doctor/Practice Fax Number____

Doctor/Practice email address____

I request AACOS to send the following Medical Records to the Doctor/Practice named above.

1. All of my health information that AACOS has in their possession including but not limited to my medical history, office visit notes, testing, visit history, financial history, prescriptions, lab results and any and all treatment received by me or the patient if under age 18. (Circle one) YES/NO

2. If you answered NO to the above question, which specific records would you like AACOS to send to the Doctor/Practice named above?
   ____
   ____
   ____

3. I request AACOS to deliver my medical records to the above Doctor/Practice via (circle one)

   i. Mail

   ii. Fax

   iii. Secure email

4. Purpose. I authorize the release of my health information or that of my minor child for the following specific purpose and or

reason.____
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Within the State of Colorado, Medical Doctors must retain medical records for six years by basic HIPAA regulations. By law, AACOS has 30 days to send your records to you and/or your doctor/doctor's office. If you require your records sooner than the allowed 30 days, please contact our medical records department at (719) 564-2503 ext 1101. Fees for generating and mailing your medical records and/or antigen may apply as allowed by Colorado law. You may view your medical records free of charge via your patient portal at www.aacos.com. AACOS reserves the right to require legal identification if needed to verify your identity and/or relationship to the patient prior to releasing medical records.

I understand that the information released is for the specific purpose stated above. I understand that I may revoke this authorization at anytime by notifying AACOS in writing. I understand that the revocation will not apply to information already released in response to this authorization. Unless otherwise revoked, this authorization will expire in one year. I understand that a photocopy or facsimile of this written request will be treated with the same effectiveness as the original.

I hereby grant AACOS permission to exchange information from my records.

Patient Printed Name____
Date_________________________________

Patient Signature (legal guardian if under 18)
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