RETINA CONSULTANTS
OF SOUTHERN COLORADO

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Retina Consultants of Southern Colorado, PC
2770 North Union Blvd., Suite 140 Colorado Springs CO 80909
Phone: (719) 473-9595 Fax: (719) 227-0669

☐ Requesting Medical Records ☐ Sending Medical Records

Please Note: It can take up to 15 business days for records to be delivered

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I AUTHORIZE RETINA CONSULTANTS OF SOUTHERN CO TO RELEASE MY HEALTH CARE INFORMATION TO:

Clinic Name: _____ **Provider Name:** _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

This request and authorization apply to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Method of Delivery: ☐ Pick up ☐ Mail ☐ Fax to #_____

Copy of: EXAM Notes ____ IMAGES: Disk Form: _____ Printed Copy: _____
Multiple visits may require more than one disk.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.