❑ Expresscare Plus
2141 N. Academy Circle
Colo Spgs, CO 80909
ph 597-4200 *fx* 597-4495
www.expresscareplus.net

CONSENT FOR RELEASE/INSPECTION & DISCLOSURE OF HEALTH INFORMATION

I hereby authorize you to disclose/release the complete medical records/PHI in your possession, as listed below, concerning my illness and/or treatment to include: HIV/HBV, drug/alcohol abuse, psychological/psychiatric conditions, STD and birth control.

I AUTHORIZE

_____
Doctor/Hospital

_____
Address

_____
City State Zip

TO RELEASE/DISCLOSE MY RECORDS/PHI TO

_____
Doctor/Hospital

_____
Address

_____
City State Zip

I understand that ecp does not release copies of medical history/examination records or consultation letters received from other healthcare providers/hospitals. ExpressCare Plus will, however, release pathology and radiology reports from other healthcare providers/hospitals.

Information to be released/inspected:

1. **Obtain a copy of**
   Medical History/examination Reports _____ Prescription Refills _____
   Radiology _____ Referral Forms _____ Cardiology _____
   Pathology _____ Messages _____
2. **Obtain a copy** of other records or specific dates of service (specify below)
   _____
   _____
3. **Inspect (look at only, no copies)** all records _____
4. **Inspect (look at only, no copies)** only specific dates of service (specify below)
   _____

I am requesting copies/inspection of these medical records for the following reason(s):

___ My physician/insurance company requests information
___ Insurance change requiring change of primary care physician
___ Moving out of town
___ Found physician closer to office/home
___ Dissatisfied with medical care (explain) _____
___ Dissatisfied with staff (explain) _____
___ Other (explain)_____

NOTES FOR YOUR INFORMATION

1. **Original** records legally belong to the treating physician.
2. Patients have the right to have copies forwarded anywhere. The doctor has an obligation to forward records within a reasonable amount of time after receiving a signed release.
3. Any person 18 years or older must sign his/her own release.
4. Our office will not release records without doctor's permission and review of records.
5. Records transferred to another physician are done at no charge. There will be a fee for any other transfer. Transfers may be done via mail or fax.
6. All medical records must be paid for in advance.
7. I understand that i may revoke this authorization in writing at any time. This release will be good for one year from the date it was signed.
8. A copy of this authorization may be utilized with the same effectiveness as the original.
9. This practice has the right to deny access in whole or in part to protected health information as provided in 164.524 Paragraph(s), sections (2) & (3) of the hipaa of 1996.
10. The health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards.

REVIEW PROCEDURES

Your request to inspect or copy your Protected Health Information will be reviewed by the physician or the privacy officer, who will determine if the information requested can be made available to you. We may be legally prohibited from making certain information available to patient representatives, including:

- Psychotherapy notes
- Information related to legal proceedings
- Information that federal or state laws prevent us from disclosing
- Information that is related to medical research in which you have agreed to participate
- Information whose disclosure may result in harm or injury to you or another person
- Information that was obtained under a promise of confidentiality

Within the limits of the law, we will make every effort to accommodate your request.

We will complete our review of your request and either arrange for you to inspect your records within 30 days or copy your records within 2 weeks of your request or payment being received, or provide you with a written explanation of any restriction on the information we can provide to you.

If we deny your request, as a whole or in part, you may request that we review that decision.

PRINTED NAME OF PATIENT	DATE	PATIENT SSN
PATIENT (OR GUARDIAN) SIGNATURE	DATE OF BIRTH	PATIENT PHONE #