ROCKY MOUNTAIN SENIOR CARE

Address: 5920 McIntyre Street, Golden, CO 80403 Phone: (720) 434-4876 Fax: (303) 225-4246

RELEASE OF MEDICAL RECORDS TO ROCKY MOUNTAIN SENIOR CARE

I AUTHORIZE THE USE OR DISCLOSURE FOR THE BELOW NAMED INDIVIDUAL

_____ _____

NAME DOB

FROM: _____

_____

_____

TO: ROCKY MOUNTAIN SENIOR CARE

5920 MCINTYRE STREET

GOLDEN, CO 80403

REASON FOR DISCLOSURE: _____

- ☐ TYPE OF RECORDS: **PAST (1) YEAR OF RECORDS TO INCLUDE**
- ☐ SPECIALIST NOTES, MOST RECENT VISIT NOTE
- ☐ PRIMARY CARE PROVIDER: RECENT H&P, LABS, DIAGNOSTIC RESULTS, MEDICATION LIST
- ☐ HOSPITAL: ADMISSIONS, DISCHARGE SUMMARY, LABS, DIAGNOSTIC RESULTS, MEDICATION LIST
- ☐ OTHER (PLEASE LIST SPECIFICS) _____
- ☐ ALL

I UNDERSTAND THAT RECORDS COPIED FOR MY PERSONAL USE MAY BE CHARGED TO ME AT THE RATE CURRENTLY SET BY THE STATE OF COLORADO AS REASONABLE AND CUSTOMARY. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING. I UNDERSTAND THAT THE REVOCATION DOES NOT APPLY TO INFORMATION RELEASED TO MY INSURANCE COMPANY IF ASSOCIATED WITH CLAIMS FOR PAYMENT OF SERVICES RENDERED.I UNDERSTAND THAT AUTHORING THE DISCLOSURE OF THIS INFORMATION IS VOLUNTARY, I HAVE THE RIGHT TO COPY (AT MY OWN EXPENSE) OR INSPECT THE RECORDS BEING DISCLOSED AS PROVIDED IN CFR 164-524. I UNDERSTAND THAT THE DISCLOSURE OF INFORMATION CARRIES THE POTENTIAL OF DISCLOSURE AND THAT ANY INFORMATION MAY NOT BE PROTECTED BY FEDERAL CONFIDENTIALITY RULES.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**