ROCKY MOUNTAIN SENIOR CARE
POWERED BY ALPINE PHYSICIAN PARTNERS

A: 5920 McIntyre Street, Golden, CO 80403 P: (720) 434-4876 F: 303-215-7492 E: fax_records@myrmsc.com

I Hereby authorize the following provider to disclose my health record,

Name of facility releasing information_____

Patient Name:_____ Patient DOB: _____

Reason for disclosure: Treatment

Please fax requested information to (303)225-4246 or mail to the above address.

Information to be disclosed:

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 or Guardian Signature/ Date

_____ Date_____

Revised 8-3-22