REQUEST FOR AN INDIVIDUAL'S HEALTH INFORMATION TO COLORADO NEURODIAGNOSTICS, PLLC

Last: _____ First: _____ Middle: _____

Other Names Used: _____ DOB: _____ SS#: _____

Address: _____

Home Phone: _____ Work Phone: _____

☐ I hereby request access to the protected health information in my health record from _____ (date) to _____ (date) maintained or created by the following providers listed below.

- ☐ Most recent progress notes
- ☐ Pathology/Lab Reports
- ☐ Radiology reports
- ☐ Radiology films
- ☐ I will pick up the copies of my records
- ☐ Mail/fax copies of my records to the individual noted below:
- ☐ Billing records
- ☐ Immunization records
- ☐ Entire health record
- ☐ Other

RECORDS FROM:	**RECORDS TO:**
Name:	COLORADO NEURODIAGNOSTICS, PLLC
Address:	4 West Dry Creek Circle, Suite 150 Littleton, CO 80120
Phone:	PH: 303-730-2883
Fax:	FX: 303-730-2471

Purpose of Request: ☐ Patient's request ☐ Dispute ☐ Referral ☐ Other: _____

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, Colorado Neurodiagnostics may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.
- Colorado Neurodiagnostics will provide 1 free copy of a patient's medical records per year if released to the patient him/herself. I understand that if my records are released from Colorado Neurodiagnostics that I may be charged for paper records, plus postage payable prior to the release of the requested records. Please make all checks payable to Colorado Neurodiagnostics.

_____ _____ _____

Signature of Patient, Parent or Legally Authorized Representative | Relationship to Patient | Date