ENT of Denver, PC
Owen Reichman, MD ● Cory Portnuff, AuD
4500 E Ninth Avenue Suite 610 ● Denver, CO 80220
Phone (303) 316-7048 ● Fax (303) 316-7061

Authorization for Use and Disclosure of Protected Health Information (HPI)

Patient Information

Name: _____ DOB: _____ SS: _____
Address: _____ Phone: _____

TO:
Dr. Owen Reichman – ENT of Denver, PC
4500 E 9th Ave Suite 610
Denver, CO 80220
Phone (303) 316-7048 Fax (303) 316-7061

From:
Name _____
Address _____
City, State Zip _____
Phone _____ Fax _____

Purpose

☐ Continuation of Care ☐ Insurance/Workers Compensation ☐ Legal ☐ Personal Use
☐ Other

Records to Be Released

☐ **Entire Medical Record**
☐ Operative/Procedure Report(s)
☐ Labs/Radiology Report(s)
☐ Emergency Room Record
☐ Outpatient Visit
☐ Special Studies
☐ Billing Record
☐ Other
☐ Behavioral Health Records
☐ Physician Orders
☐ Medication Record

Authorization

ACKNOWLEDGMENT: I request and authorize the above-named healthcare provider to release the information specified above to the organization or individual named on this request. I understand that the information released my include information regarding the following conditions: Human Immunodeficiency (HIV), Alcoholism, Alcohol Abuse, if any: Acquired Immune Deficiency Syndrome (AIDS); or Psychological or psychiatric conditions, if any.

Initial: _____

I understand that:

1. My signature on this form is strictly voluntary.
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to our receiving the revocation. Further details can be found in the notice of privacy practices.
3. If the requestor or receiver is not a health plan or health care provider, the released information maybe disclosed by the recipient and may no longer be protected by federal privacy regulations.
4. Fees/charges for copies of medical records will comply with all laws and regulations applicable.

Delivery Instructions

☐ Call requestor for pick-up when records are ready.
☐ Mail records directly to person or organization specified.
☐ Fax records to _____
☐ I authorize the below listed person to pick up my Protected Health Information (PHI)
Name (please print) _____ Relationship

Signature

My signature is required to validate this Authorization. If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected.

_____

Patient or Authorization Representative Relationship to Patient Date

Note: This request will expire twelve months from the date it was signed, or upon the receipt of the request information.
Other Conditions: A copy or facsimile of this Authorization with my signature may be used with the same effectiveness as an original