Centralized Medical Records
8200 E Belleview Ave., Suite 200E, Greenwood Village, CO 80111
Phone 720-493-3242 / Fax 720-874-4433 ♦ medical.records@riaco.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:		**Date of Birth:**	
MRN:		**Name of Person Requesting Records:**	
Phone Number of Person Requesting Record:		**Requestor's Relationship to Patient:**	
I am requesting a copy of:	Report(s) for Specific Exams		
If not requesting entire medical record, specify records requested:	**Date of Exam(s):** **Type of Exam(s):** *Examples: Mammogram, CT Chest, MRI Knee*		

I authorize you to request this medical record from:

Release my Medical Record to the person/entity listed below in the following format: I will pick up CD of Images

FAX OR E-MAIL – REPORTS ONLY, IMAGES CANNOT BE FAXED OR EMAILED (NO CHARGE): Subject Line: **Attention:**	**REGULAR MAIL (NO CHARGE) OR OVERNIGHT DELIVERY (FEE APPLIES):** Regular Mail (no charge)

Please confirm your understanding of the following:

→It is important for a physician to explain the information contained in medical records and for the patient to have follow-up care as needed.

→I am not required to authorize the disclosure of my medical record to a third party and my authorization to disclose my medical record is strictly voluntary.

→My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.

→I may revoke this authorization at any time in writing to the address on the top of this form, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.

→This authorization will expire, without my expressed revocation, either one year from the date of signing or, if signing for a minor, the date the minor child becomes an adult according to state law, whichever occurs first.

→If the requestor or receiver of the medical record is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed by the receiver without my knowledge or authorization.

→I may see and obtain a copy of the information described on this form, if I request it.

→I can receive a copy of this form after I sign it.

→If I have any questions about my privacy rights, I may contact the RIA/Invision Privacy Officer at (720) 493-3731.

Patient Signature:		Date:	
Legal Representative Signature:		Date:	

Return this form to Medical Records via Fax 720-874-4433 or Email: medical.records@riaco.com