

**AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION
REQUEST TO RELEASE REPORTS & IMAGES**

All information must be completed or we will be unable to fulfill your request.

Patient Name: _____ DOB: _____ MRN: _____
(PRINT) (OFFICE USE)

Patient Name on Previous Records (maiden name or nickname): _____
(PRINT)

RELEASE: Reports (mail, fax, or email) Images (mail or pick up) Reports and Images
To: Patient Physician/Facility Name _____ Other _____
Send by: Mail Fax Email

Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____
Email: _____

All Records
 Specific Exam: X-Ray Ultrasound CT MRI All breast imaging Genetic Counseling
 Other _____

Specific Exam Date: _____ Specific Date Range: _____

Purpose: Comparison Continuation of Care Workers' Compensation Attorney Insurance Other
Reports and/or images needed by this date: _____

PRIORS: Request to obtain prior reports and images only: **FAX:** 720.874.4433 **EMAIL:** prior.records@riaco.com

REQUEST: Prior Reports and/or Images:

From: Facility Physician: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Fax: _____

I understand that:

- It is important for a physician to explain the information contained in medical records and to have follow-up care as needed.
- I am not required to authorize the disclosure of my medical record to a third party and that my authorization to disclose 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 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, for a reasonable fee, 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 Compliance Hotline Number at 720.493.3788.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient: _____ Date: _____
Legal Representative: _____ Date: _____
Witness: _____ Date: _____