Part of Optum®

TRANSFER OF MEDICAL RECORDS

Patient Name: ____________________
Date of Birth: ____________________
Phone Number: ____________________

REASON FOR RELEASE:

☐ Moving: ☐ Out of State ☐ Within Colorado ☐ Provider Retiring/No longer at New West
☐ Dissatisfied with Practice/Provider ☐ Insurance ☐ Continuity of Care
☐ Other: ____________________

RELEASE FROM:

Name: ____________________
Address: ____________________
____
____
____
Phone: ____________________
Fax: ____________________

RELEASE TO:

Name: ____________________
Address: ____________________
____
____
____
Phone: ____________________
Fax: ____________________

I request and authorize this transfer and release of my medical record to and from the medical practice listed above. I understand that this documentation includes all forms of Protected Health Information (PHI) and is also applicable to the electronic transfer of records if the if the requested recipient is able to accept and access encrypted information from the New West Physicians' Electronic Medical Record. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

☐ **Entire Record - OR:** ☐ **X-Ray Reports** ☐ **Medications**
☐ **Doctor's Notes** ☐ **Laboratory Reports** ☐ **Diagnoses**
☐ **Pathology Reports** ☐ **Diagnostic Studies** ☐ **Other** ____________________

Due to the sensitivity of the following information, please check off and initial if you would like the following information to be released:

☐ Notes and reports related to STDs including HIV/AIDS ________ Initial
☐ Psychiatry/Mental Health Notes ________ Initial
☐ Notes related to Drug/Alcohol Abuse ________ Initial

I understand that New West Physicians will no longer be responsible for the protection of the PHI except in its original format in their records. I understand that my health information may be subject to re-disclosure by the recipient and if the recipient is not a health plan or health care provider, the information may not longer be protected by the federal privacy regulations. This authorization will expire one year from the date I sign it. I understand the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present the written revocation to the Site Practice Manager. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

PLEASE NOTE: THERE MAY BE A CHARGE FOR THE COPYING OF RECORDS

In Accordance with Chapter 2, Part 5, sections 5.2.3.4 of the Colorado Regulations of Health Facilities, the cost of this information cannot exceed $18.53 for the first 10 or fewer pages and $.85 per page for pages 11 through 40, $.57 per page after 40 pages. Actual postage or shipping costs and applicable sales tax, if any, may be charged. We will not be able to process your request until the following payment is received.

____________________ ____________________

Signature of Patient **Date**

Signature of authorized Representative (if patient is a minor or unable to sign)

Attach copy of Durable Power of Attorney if patient is adult