Advanced Reproductive Medicine UNIVERSITY OF COLORADO	Medical Record #: Patient Name: Date of Birth: SSN:

AUTHORIZATION TO RELEASE AND/OR OBTAIN PATIENT INFORMATION

OBTAIN FROM: (Releasing facility)	**RELEASE TO: (Receiving entity)**
_____ Name	_____ Name
_____ Address	_____ Address
_____ City State Zip	_____ City State Zip
_____ Phone Fax	_____ Phone Fax

I hereby give the releasing facility permission to disclose my individually identifiable health information as listed below. I understand that once this information is disclosed, it may no longer be protected by University of Colorado Advanced Reproductive Medicine. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization and that there may a cost to copy the records.

INFORMATION TO BE RELEASED (check all that apply):

Date of service range (month/year): From: _____ To: _____

_____ Emergency Room Report	_____ Mental Health Treatment	_____ Genetic Information
_____ Discharge Summary	_____ Drug/Alcohol Treatment	_____ HIV/AIDS
_____ Operative Report	_____ Radiology Reports	_____ X-ray Films (maintained by Radiology Dept.)
_____ History and Physical	_____ Laboratory Reports	_____ Immunization Records
_____ Clinic/Progress Notes	_____ Other test results: _____	

INFORMATION IS TO BE USED FOR:

_____ Continuity of Medical Care _____ Damage/Claim Information _____ Personal Use

Other: _____

AUTHORIZATION: I understand that I can take back permission to release my medical records at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire 180 days from the date of my signature unless I provide notice in writing that it should be revoked. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy or facsimile of this form is to be considered as valid as the original.

_____ _____
Signature of Patient or Authorized Representative *Date of Signature*

_____ _____
Printed Name *Relationship to Patient (if applicable)*