Allergy, Asthma & Immunology of the Rockies, P.C.

Patient information

Patient Name_____ Date of Birth _____ AAIR # _____

Address_____

City _____ State _____ Zip _____

Phone # _____

Release From

I hereby authorize:

(□) AAIR, 120 Midland Ave., Suite. 230, Glenwood Springs, CO 81601
PH(970)947-0600 Fax (970)947-0601

Other:

_____

_____

City/State/Zip Phone Fax

Release to

Release to:

(□) AAIR, 120 Midland Ave., Suite 230, Glenwood Springs, CO 81601
PH(970)947-0600 Fax (970)947-0601

Other:

_____

_____

City/State/Zip Phone Fax

Information to Be Released

(Circle all applicable categories)

□ Complete Copy of All Records □ Lab Reports □ Skin Test Results
□ Office/Consultation Reports □ X-Ray/CT Reports
□ Other (specify)

State/Federal Laws require specific authorization to release the following types of information. Please check beside the types of information to be released:

□HIV/AIDS Related □ Genetic Testing □ Drug/Alcohol Abuse
□Mental Health □ Psychotherapy Notes □ Developmental Disabilities

For the Following Dates:

Purpose or Need for Disclosure

(Circle all applicable categories)

□ Continuation of Care □ Insurance □ Personal Use
□ Legal Use □ Other (specify)

Authorization

I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original. I understand the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. My signature on this form is voluntary and I do not need to sign this form to ensure health care treatment. This authorization is valid for 12 months from the date of signature. I understand that I may revoke this authorization at any time in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signature

Patient/Legal Guardian Signature_____Date_____

Witness Signature_____Date _____

Fees

Pages	1-10	11-40	41+
Patient	$14.00	.50 each	.33 each
Others	$16.50	.75 each	.50 each

According to Colorado State Statute, 6 C.C.R. 1011-1, Chapter 2 Part 5.2.3.4 the following fees may be charged for copies of medical records.
Actual postage may be charged
Records will be provided to other health care providers at no charge.

Once AAIR receives your authorization to release information, it will take approximately 7-10 Business days for the record to be photocopied and faxed/mailed to the address you provide. Occasionally delays occur. We will attempt to contact you if extra time is needed to process your request.

_____

AAIR : office use only

Date received: Reviewed:

AllerVie HEALTH

allervie.com

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name: _____ Physician: _____

Social Security Number: _____ Date of Birth: _____

Address: _____ Account Number: _____

I hereby authorize AllerVie Health to use, disclose and/or obtain my health information as follows *(check all that apply)*:

- ☐ **Use** the following health information maintained by AllerVie Health until *(if no date this release will expire after 1 year)*: Date: _____
- ☐ **Disclose** health information to: _____
  Address: _____ City, State, ZIP: _____
  Phone: _____
- ☐ **Obtain** health information from: _____
  Address: _____ City, State, ZIP: _____
  Phone: _____

Specific description of the health information to be used/disclosed/obtained *(include dates of service, i.e., appointment date, type of service, etc)*:

_____

This health information is used/disclosed/obtained for the following purpose *(if Authorization requested by the patient put: "At the request of the individual")*:

_____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is **voluntary**. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.
3. I understand that I may revoke this Authorization at any time by notifying AllerVie Health in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.

_____ _____ _____

Signature of Patient or Patient's Representative | Printed Name of Patient's Representative *(if applicable)* | Date

Representative's Relationship to Patient (if applicable): _____

Please list AllerVie location(s) that you receive healthcare from:

Name of Location: _____

Address: _____ City, State, ZIP: _____

Please send all record requests to your local AllerVie Health location. To find the location nearest you, please visit **allervie.com**.