New West PHYSICIANS
We put your health first

Transfer of Medical Records
PATIENT INFORMATION
PLEASE PRINT

Reason for Release:

□ **Moving**: □ Out of State □ Within Colorado
□ **Provider Retiring / No longer at New West**
□ **Dissatisfaction with practice / provider**
□ **Insurance** □ **Continuity of Care**
□ **Other:** _____

Name: _____

Date of Birth: _____

Phone Number: _____

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 may not be denied treatment or payment for health care services if I do not sign this form.

□ **ENTIRE RECORD - OR:**
□ **Doctor's Notes**
□ **Pathology Reports**
□ **X-Ray Reports**
□ **Laboratory Reports**
□ **Diagnostic Studies**
□ **Medications**
□ **Diagnoses**
□ **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 no longer be protected by the federal privacy regulations. This authorization will expire one year from the date I sign it. I understand I have 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