Matthews-Vu
Healthcare for Children and Adults

(Incoming Records)
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Patient: _____

Date of Birth: _____

Telephone Number: _____

Requesting Records from:	**Where to send the records to:**
Name/Facility: _____	Matthews-Vu Medical Group
Attention: _____	Attention: Medical Records
Address: _____	4190 E Woodmen Rd, Ste 100 Colorado Springs, CO 80920
City: _____ State: _____ Zip: _____	
Phone: (____)_____ FAX: (____)_____	Phone: (719) 632-4455 Fax: (360) 462-5181

Please send records from the following date range: from: _____ to: _____

- ☐ All
- ☐ History and Physical
- ☐ Consultation Notes
- ☐ Progress Notes
- ☐ Labs
- ☐ Other:_____
- ☐ Behavioral Health

Purpose of requested use or disclosure:

- ☐ Continuing Care
- ☐ Patient Request*
- ☐ Insurance*
- ☐ Legal*
- ☐ Other

***Copy Fee**: We reserve the right to charge a reasonable fee for the cost of producing and mailing the copies. Base fee of $20.00 per chart for personal records. Please make checks payable to Bactes.*

I specifically authorize release of the following information (check and initial as appropriate):

- ☐ Mental health treatment information — Initial if requesting: _____
- ☐ HIV test results — Initial if requesting: _____
- ☐ Alcohol/drug treatment information — Initial if requesting: _____

If not checked and initialed, the records containing such information can NOT be released.

Duration: This Authorization expires [insert date]: _____
If no date is given; this authorization will expire 6 months from the signature date.

Revocation: I may revoke this authorization at any time, but I must do so in writing and submit it to Matthews-Vu. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Re-disclosure: Information disclosed pursuant to this authorization could be re-disclosed by the recipient and no longer protected by federal privacy regulations.

Conditioning: I may refuse to sign this Authorization. If I refuse to sign this Authorization, I should know that by law, my health information cannot be released. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

This authorization is being requested of you to comply with the terms of the Confidentiality of the Medical Information Act of 1981, Civil Code Section 56 et seq. and the Health Insurance Portability and Accountability Act (HIPAA) of 2003.

Patient Signature: _____ **Date:** _____

Legal Representative Signature: _____ **Relationship to Patient:** _____