



**(Outgoing Records)**  
**AUTHORIZATION FOR USE OR**  
**DISCLOSURE OF HEALTH**  
**INFORMATION**

**Patient:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

<p><b>Requesting Records from:</b>          Matthews-Vu Medical Group</p> <p>Attention to Medical Records</p> <p>4190 E Woodmen Rd. Ste 100          Colorado Springs, CO 80920</p> <p>Phone: (719) 632-4455 Fax: (719) 633-4613</p>	<p><b>Where to send the records to:</b>          Name/Facility: _____</p> <p>Attention: _____</p> <p>Address: _____</p> <p>City: _____ State: _____ Zip: _____</p> <p>Phone: (____) _____ FAX: (____) _____</p> <p><input type="checkbox"/> Check box if you prefer a CD.</p>
--	---

**Please send records from the following date range:** from: \_\_\_\_\_ to: \_\_\_\_\_

<input type="checkbox"/> All	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Consultation Notes
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Labs	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Behavioral Health		

**Purpose of requested use or disclosure:**

<input type="checkbox"/> Insurance*	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Patient Request*
	<input type="checkbox"/> Legal*	<input type="checkbox"/> 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):**

<input type="checkbox"/> Mental health treatment information	Initial if requesting: _____
<input type="checkbox"/> HIV test results	Initial if requesting: _____
<input type="checkbox"/> 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:** \_\_\_\_\_