CONSENT TO RELEASE MEDICAL RECORDS

BOULDER EYE SURGEONS
Donald Keller MD, Brian Nichols MD PhD & Kevin Cuevas MD
4745 Arapahoe Avenue Suite 100 Boulder, CO 80303
Phone (303) 444-3000 Fax (303) 444-3226

I hereby authorize the use or disclosure of my individual health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient name:	Birthdate:
Address:	

From (Physician/Facility)	**To (Physician/Facility)**
Address:	
Phone:	Phone:
Fax:	Fax:

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that this authorization will expire on __/__/__ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in 6 months. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. Any chart with more than 10 pages will be mailed.

_____

Signature of patient or patient's representative

Printed name:_____ Date:_____

Relationship to the patient: ☐ Self ☐ Parent ☐ Legal Guardian