



BE WELL PRIMARY CARE LLC

19600 E. Parker Square Dr. Ste 120
Parker, CO 80134
720-770-0966

HIPPA Release of Records Consent

Please complete **ALL** sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

PLEASE RELEASE INFORMATION TO/FROM (Circle one):

BE WELL PRIMARY CARE LLC
19600 E. Parker Square Dr. Suite 120
Parker CO 80134
Office: 720-770-0966 Fax: 1-844-689-2476

PLEASE RELEASE INFORMATION TO/FROM (Circle one):

Doctor's Name/Clinic/other: _____
Address: _____
Fax number: _____ Office phone number: _____

PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____
Address: _____
Social security number: _____ Phone Number: _____

Dates of treatment to be released: from: _____ to _____ or ALL DATES

PLEASE CHECK OFF WHAT MEDICAL INFORMATION YOU WISH TO BE RELEASED:

- | | | |
|---|--|--|
| <input type="checkbox"/> ENTIRE CHART | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> ER reports |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Progressive notes | <input type="checkbox"/> Radiology Reports | |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> ECG/EEG/Cardiac Testing | |

I DO or I DO NOT: Authorize release of information related to Aids or HIV infection, psychiatric care, and/or psychological assessment.

REQUIRED: Purpose of disclosure:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Personal | <input type="checkbox"/> Attorney/Legal | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Changing Doctors | <input type="checkbox"/> Referral to Specialist | _____ |

I understand that I may refuse to sign this authorization. Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits. I may take back (revoke) this authorization in writing, except for any actions already taken based upon it. I understand that this authorization will expire in 1 year or when the records are released for the request dated below. Any requests after this date will need a separate authorization. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy rules and may be shared with others. I have been offered a copy of this authorization.

SIGNATURE of PATIENT or GUARDIAN: _____ DATE: _____

PRINTED NAME: _____