Epstein Neurosurgery Center, LLC
Epstein Neurosurgery Foundation, Inc. 501(c)(3)
Clinical Office By Appointment Only: 109 N. 2nd St., Suite #102, Westcliffe, CO 81252
Phone: 303.800.9129/Fax: 720.638.0497
Clara Raquel Epstein, MD, FICS
Neurosurgeon/CEO
www.epsteincenter.com
www.epsteinfoundation.org

PATIENT NAME _____ **DATE OF BIRTH**_____/_____/_____

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Release From (Name, Institution, Mailing Address, Phone # and Fax#):

_____

Check as appropriate:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

OR

☐ Disclose my complete health record except for the following information
☐ Mental health records
☐ Communicable diseases including, but not limited to, HIV and AIDS
☐ Alcohol/drug abuse treatment records
☐ Genetic information
☐ Other (Specify)

Reason for Disclosure: _____

Release To (Must Include all the following - Name, Institution, Mailing Address, Phone # and Fax#):

_____

_____

I authorize the above-named healthcare provider/institution to release information to the organization/agency/individual named on this request. The purpose of this release is continuance of care. The method of release shall be pertinent to the need and may include photocopies, fax copies, personal review, audio, video, electronic, or verbal communication by the appropriate practitioner. I understand that except for drug and alcohol treatment records, information disclosed under this authorization may be re-disclosed by the recipient and is no longer protected by privacy laws.

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HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (Continued)

I understand that I may revoke this authorization at any time, except to the extent that action has already taken place to comply with it. Without my expressed revocation, this authorization will automatically expire one year from the date of my signature.

A copy of this authorization (including a facsimile copy) may be used with the same effectiveness as the original.

Patient Signature: _____ Date: _____

Authorized Representative Name: _____ Relationship: _____

Authorized Representative Signature: _____

Witness: _____ Date: _____

Please fax this completed form to 720.638.0497**. You will then receive an invoice and instructions for payment through the portal. Fees charged are defined under Colorado law C.R.S. 25-1-801. Your records will be sent upon receipt of payment.** Please allow four to six weeks for processing your request.