Epstein Neurosurgery Center, LLC
Epstein Neurosurgery Foundation, Inc. 501(c)(3)
Clara Raquel Epstein, MD, FICS
Neurosurgeon/CEO
www.epsteincenter.com
www.epsteinfoundation.org

Administrative Office:
6940 N. 63rd Street
Longmont, CO 80503-8852
Phone: 303.800.9129
Fax: 720.638.0497

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

HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name (First/Middle/Last): _____ DOB: _____

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 health care provider/institution to release information to the organization/agency/individual named on this request. The purpose for 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 appropriate practitioner. I understand that except

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for drug and alcohol treatment records, information disclosed under this authorization may be redisclosed by the recipient and is no longer protected by privacy laws.

I understand that I may revoke this authorization at any time, except to the extent that action has already been 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.