Rocky Mountain Movement Disorders Center, P.C.

701 E. Hampden Ave Ste 510 Englewood CO 80113
Phone (303) 357-5455 Fax (303) 357-5459

AUTHORIZATION FOR RECORDS RELEASE

Patient Name: ___________________________________ D.O.B. ____________________________

Phone #: _______________________________________

- ❑ **To obtain outside records:** For use by Rocky Mountain Movement Disorders Center, P.C. (RMMDC)

And/or *(We recommend selecting both)*

- ❑ **To obtain outside records:** For clinical research trials with RMMDC & Colorado Neurological Institute

- ❑ **To release records to another provider:**
I authorize Rocky Mountain Movement Disorders Center, P.C., to disclose my protected health information as requested below.

Required information:

Requesting records from or to (name)____

Address____

Phone____________________________________ Fax___________________________________

All Requests:

- ❑ Please release ALL medical records pertaining to neurology and movement disorders
- ❑ Specific dates of service only: From____________________ To______________________
- ❑ Request for specific documents:

____ MRI Reports	____ Progress Notes	____ CT Reports
____ MRI CD	____ Lab Reports	____ CT CD
____ EMG Reports	____ X-Ray Reports	____ DaTscan

____ Other Diagnostic Reports (specify)____

____ Other (specify) ____

I understand that this release will remain in effect unless I revoke this authorization at any time, by sending a written notification to RMMDC's privacy officer at: 701 E. Hampden Ave., Suite 510, Englewood, CO 80113. If I choose to revoke this authorization, I understand that my written revocation will not pertain to protected health information as outlined by my insurance carrier's provisions.

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Signature of Patient or Patient's Representative Date

____

Please print name & relationship to the patient Date