



A · RENAISSANCE  
IN · WOMEN'S  
HEALTHCARE

### Authorization for Release of Medical Records

Please print patient identification:

**NOTE: WE ASSESS A \$15 FEE FOR PROCESSING THIS RELEASE OF YOUR MEDICAL RECORDS.**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security \_\_\_\_\_ Phone \_\_\_\_\_

I understand that, as a part of my health care, Rygiel's Renaissance in Women's Healthcare, P.C. (Rygiel's Ren.) receives, originates, maintains, discloses, and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans and billing and health insurance information. I understand that Rygiel's Renaissance and its physicians, other health care professionals, and staff may use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations.

I hereby knowingly and voluntarily disclose information from my previous care.

FROM: \_\_\_\_\_

\_\_\_\_\_

Send records TO: \_\_\_\_\_

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Rygiel's Renaissance in Women's Healthcare, P.C.  
8890 N. Union Blvd. Suite 175, Colorado Springs, CO 80920  
**FAX: 719-282-4067**

Records to be released: \_\_\_\_\_ All records and labs  
 \_\_\_\_\_ Immunization \_\_\_\_\_ Operative Reports \_\_\_\_\_ Laboratory Reports  
 \_\_\_\_\_ Diagnostic Tests \_\_\_\_\_ Physician Notes \_\_\_\_\_ Workers Compensation

Rygiel's Renaissance in Women's Healthcare, P.C.  
8890 N Union Blvd, Ste 175, Colorado Springs, CO 80920-2701  
Phone: 719-282-4066

If information to be released is to include that relating to alcoholism and/or drug abuse, mental health/rehabilitation, and /or HIV/AIDS testing or diagnosis, the appropriate section(s) MUST BE MARKED:

\_\_\_\_\_The records relating to the diagnosis and /or treatment of alcoholism and/or drug abuse or dependence may be released to the recipient noted on the authorization above.

\_\_\_\_\_The records relating to the diagnosis and/or treatment concerning mental health/rehabilitation may be released to the recipient noted on the authorization above.

\_\_\_\_\_The records relating to the diagnosis and/or treatment for HIV/AIDS may be released to the recipient noted on the authorization above.

I understand that only the areas marked at the time this release was signed will be released/disclosed.

I understand that I may revoke this consent in writing but the revocation will not affect the extent that Rygiel's Renaissance in Women's Healthcare has already taken action in reliance on my effective consent.

I understand that I must deliver the written revocation to: Rygiel's Renaissance in Women's Healthcare at 8890 N. Union Blvd., Suite 175 Colorado Springs, CO 80920 where Dr. Rygiel, Dr. Christenson and Susan Anderson, N.P. reside.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by the privacy regulations.

A copy of this authorization may be used with the same effectiveness as the original. This authorization expires on (date)\_\_\_\_\_.

X \_\_\_\_\_  
Signature of Patient

X \_\_\_\_\_  
Signature of Witness

Date:\_\_\_\_\_

Date:\_\_\_\_\_

If the authorization is signed by a personal representative, a description of the representative's authority to act is as follows:\_\_\_\_\_

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Signature of Witness

Date:\_\_\_\_\_

Date:\_\_\_\_\_

Revised 1/08, this form is HIPAA Compliant.

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