

**CONSENT TO RELEASE MEDICAL RECORDS
BOULDER EYE SURGEONS**

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I hereby authorize the use or disclosure of my individual health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient name:	Birthdate:
Address:	

From (Physician/Facility)	To (Physician/Facility)
Address:	
Phone:	Phone:
Fax:	Fax:

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that this authorization will expire on __/__/__ (DD/MM/YR). If I fail to specify an expiration date, this authorization will expire in 6 months. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any actions they took before they received the revocation. Any chart with more than 10 pages will be mailed.

Signature of patient or patient's representative

Printed name: _____ **Date:** _____
Relationship to the patient: Self Parent Legal Guardian