Sinus Solutions AT IMMUNOe

SMOKY HILL
15470 E SMOKY HILL RD, AURORA, CO 80015
P: 303.224.4711 | F: 303.388.0959

CHERRY CREEK
3150 E 3rd Ave #300, Denver, CO 80206
P: 303.224.4711 | F: 303.388.0959

MEDICAL RECORD ACCESS PERMISSION FORM

PROTECTED HEALTH INFORMATION

Please indicate below any person that is permitted to have access to your protected medical information or speak to provider/office staff regarding your care. This may include test results, medical records, plan of action, billing, etc. Please be aware, you can provide any "exceptions" for what you would like to be withheld from stated individual. An example of an "exception" may be "do not release lab work results" or "do not release billing information."

☐ I do not wish to list any individuals to have access to my medical information.

☐ I do wish to have the following individuals have access to my medical information. If there are exceptions to what they may have access to, I have notated this.

Name: _____

Relationship to patient: _____ Phone Number: _____

Exceptions: _____

Name: _____

Relationship to patient: _____ Phone Number: _____

Exceptions: _____

Name: _____

Relationship to patient: _____ Phone Number: _____

Exceptions: _____

By signing below, I confirm that I have reviewed this information and that it is correct. Sinus Solutions will consider this form to be true and accurate. If I should decide to make changes any of the above information, it must be made in writing.

Patient Name (Printed): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Expiration of this Consent: ☐ Never ☐ After this date: _____