



26659 Pleasant Park Rd
 Conifer, CO 80433
 Phone: (303) 647-5300
 FAX: (303) 647-5299

Patient Full Name: _____

DOB: __ __ / __ __ / __ __

Previous/Other Name: _____

Phone: _____

This will authorize: *(If different than patient listed above)*

To Release to:

GENERAL INFORMATION REQUESTED

Medical Information Requested:

Reason for Release:

<input type="checkbox"/> Complete records	<input type="checkbox"/> Changing doctor
<input type="checkbox"/> Labs	<input type="checkbox"/> Dissatisfaction with care
<input type="checkbox"/> X Ray reports	<input type="checkbox"/> My insurance changed
<input type="checkbox"/> Partial record, dates:	<input type="checkbox"/> Specialist consult

Other:

I am moving, new address:

AUTHORIZATION FOR RELEASE OF SPECIFIC INFORMATION PROTECTED BY FEDERAL LAW

I specifically authorize the release of data and information relating to (Note, **you must mark yes or no**):

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Substance Abuse (alcohol/drug abuse)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mental Health/Depression (includes psychological testing)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV-Related Information (AIDS related testing)

This consent may be revoked at any time by notifying the above named provider of information in writing. Any release of information made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosed information may be reviewed by contacting the provider of information.

RESTRICTIONS:

The authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.

Signature of Patient or Responsible Party: _____

Today's Date: _____

Date Authorization Ends: _____