26659 Pleasant Park Rd
Conifer, CO 80433
Phone: (303) 647-5300
FAX: (877) 892-7288

Patient Full Name: ____________________________________ **DOB**: ____/____/_____

Previous/Other Name: ____________________________________ **Phone:** _______________

(If different than patient listed above)

This will authorize:

Facility: _________________________________

Phone: _________________________________

FAX: _________________________________

To Release to:

Facility _________________________________

Phone: _________________________________

FAX: ______________________________

GENERAL INFORMATION REQUESTED

Medical Information Requested:	Reason for Release:
☐ Complete records	☐ Changing doctor
☐ Labs	☐ Dissatisfaction with care
☐ X Ray reports	☐ My insurance changed
☐ Partial record, dates:	☐ 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**):

Yes	No	
☐ Yes	☐ No	Substance Abuse (alcohol/drug abuse)
☐ Yes	☐ No	Mental Health/Depression (includes psychological testing)
☐ Yes	☐ 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: ________________________