AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

TO:

Patient's Name:
Patient's Address:

Date of Birth:
Social Security Number:

- I authorize the information to be disclosed to and used by the following individual or organization:

- The type and amount of information to be disclosed is as follows: *(specify dates where appropriate)*

¡ Immunizations
¡ Most Recent 3 Years of Record
¡ Entire Medical Record
¡ X-Ray Films (specify type/dates): _____

¡ Laboratory Results, from date _____ to date _____
¡ X-Ray Reports, from date _____ to date _____
¡ Genetic Testing, from date _____ to date _____
¡ HIV/AIDS information, from date _____ to date _____

Other: _____

- I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
- I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
- I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I accept full responsibility for copying fees. Per Colorado Department of Health and Public Environment Regulations, the fee for copying requested documents is $14.00 for the first ten pages, $.50 per page for pages 11-40 and $.33 per page for each page over 40. There is no charge for records sent to another health care provider.
- Do not disclose information to any other persons without written authority from me.
- All prior authorizations are cancelled.
- Photocopies of this authorization are to be given the same effect as the original.

_____ _____
Signature of Patient or Authorized Personal Representative Date

_____
Personal Representative's Name (print) and Relationship