Authorization for Disclosure of Health Information

I hereby authorize ______________________________________ to release medical information from the records of:
(Name of Facility)

Patient Name: ____ Date of Birth: ____/____/____

Patient Street Address: ____

City: ____ State: _____________________ Zip Code: _______________

Date(s) of Treatment Requested: ____

Information to be disclosed (check all applicable items to be released):

□ Commitment Papers	□ EKG/ECG Tests	□ Lab Reports	□ Progress Notes
□ Consultations	□ ER Record	□ Medication Records	□ Therapy Notes
□ Discharge Summary	□ History and Physical	□ Nurse's Notes	□ Treatment Plans
□ Discharge Instructions	□ HIV Testing	□ Operative Report	□ X-Ray Reports
□ Doctor's Orders			

□ Other (please specify): ____

Purpose of Need for the Disclosure Is:

□ Continued Medical Care □ Insurance □ Legal □ Patient's Own Use □ Other: _______________________

The information may be disclosed to:

Geriatric and Family Medicine Associates, LLC.
3885 Upham Street, Suite 100
Wheat Ridge, Colorado 80033
Phone: 303-742-0086 Fax: 303-742-9995

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: ______________________ or upon the following event: __________________________
(Date)
If no date or event is specified, this authorization will expire in six months from the date of signature.

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, genetic information, sexually transmitted infections/diseases, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC), and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

____ _________________________________
(Signature of Patient or Personal Representative)* *(Date of Signature)*

*If signed by a personal representative, a description of the representative's authority to act is as follows:
□ Parent □ Legal Guardian □ Health Care Power of Attorney □Administrator
□ Executor of Estate □ Next of Kin □ Beneficiary