Please note: To fill out this form using the editable fields in the PDF, you must first save to your computer and open using Adobe Reader.

Mile High Family Medicine
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Lakewood, CO 80226
Phone: 303-936-0022
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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize the disclosure of health information of the individual named below:

Patient Name: _____ Date of Birth: _____
Address: _____
Phone: _____ SSN: _____

Records Requested From: **To Be Disclosed and Used By**:

_____ _____
_____ _____
_____ _____
Phone:_____ Phone: _____
Fax: _____ Fax: _____

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

- ☐ Entire Medical Record
- ☐ Immunization
- ☐ Most Recent 3 years
- ☐ X-ray reports
- ☐ Laboratory Results from _____ to _____
- ☐ X-Ray Reports from _____ to _____
- ☐ Genetic testing from _____ to _____
- ☐ HIV/AIDS Information from _____ to _____

Other: _____

Purpose: _____

3. 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.
4. I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that in writing I may revoke this authorization except to the extent that any action has been taken on this authorization. In addition, I understand that the revocation will not apply to information previously released as a consequence of this authorization or to my insurance company where the law provides my insurer with the right to contest a claim under my policy or the policy itself.
5. I understand that authorization for disclosure of this health information is voluntary and may be refused. I understand that any disclosure allows for the potential for un-authorized re-disclosure and the information may not be protected by federal confidentiality rights.
6. Per Colorado Department of Public Health and Environmental Regulations, no fees shall be charged by a health care provider to another health care provider who has received patient records.

_____
Signature of Patient or Authorized Representative Date

_____
Please print Name and indicate relationship Date