PEAK HEALTH FAMILY MEDICINE

Authorization for Release of Information

Patient Name (First, Middle, Last):	DOB:
Address:	Phone:

This Authorization applies to the following Information:

[ ] **All Information**; I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

[ ] **Only** the following records or types of Information:

[ ] Office Visits [ ] Labs [ ] ETOH/substance abuse record
[ ] HIV/STD records [ ] Radiology [ ] Other (Please specify)
[ ] Mental Health record [ ] EKG, Spirometry _____

Treatment Dates: from (month/date/year): ____/____/_____ to _____/____/_____

Previous Medical Provider and Address:	Phone: Fax:
Disclose Information to:	
Peak Health Family Medicine **5920 S. Estes St. Suite 250** **Littleton, CO 80123**	Phone: 303-973-3529 Fax: 303-973-3549

Purpose of the release:

[ ] Change of Primary Care Provider [ ] **Other** *(Please specify):*_____

This authorization ends: [ ] on (date) _____ If no date is specified, this authorization will end after 180 days from date of signature.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact Peak Health Family Medicine.

For patient medical records that exceed over 30 pages please send records by mail. We appreciate your help. Thank you in advance.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by Peak Health Family Medicine based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

_____ _____ _____

Signature of Patient/Legal Guardian **Printed Name** of Patient/Legal Guardian Date