

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**I authorize following individual or organization:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**To release the health information of the individual named below:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Information to be disclosed:**

All Medical Records     Medical Notes/Summary     Operative/Procedure Reports  
 Pathology     PAP/HPV type     Mammograms/Sonograms     Bone Density     Lab  
Results     AIDS/HIV Information     Other: \_\_\_\_\_  
(specify dates where appropriate)

**Purpose of Disclosure:**

Continuing medical treatment     Residence Relocation     Second Opinion     FMLA  
 Disability Insurance     Patient Request     Life Insurance     Other: \_\_\_\_\_

**Send records to:**

Midtown OB/GYN, 2005 Franklin Street, Midtown II, Suite 440, Denver, Colorado 80205

**Authorization & Signature:**

-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 one year from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. 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 this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(or guardian or legal representative)