AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

~ Records Released TO Midtown OB/GYN ~
4600 Hale Parkway, Ste. 400
Denver, CO 80220
(303) 321-2166
(303) 861-7211 fax

I authorize the following individual or organization:

Name: ____
Address: ____
City: ____________________ State: __________ Zip: ____________________
Phone #: ____________________ Fax #: ____________________

To release medical information for the following individual:

Patient Name: ______________________ Date of Birth: _____/______/_____
Address: ____
City: ____________________ State: __________ Zip: ____________________
Phone #: ____________________ SSN: ____________________

Information to be disclosed: (Specify dates where appropriate)

- ☐ All Medical Records
- ☐ Medical Notes/Summary
- ☐ Operative/Procedure Reports
- ☐ Pathology
- ☐ PAP/HPV Type
- ☐ Mammograms/Sonograms
- ☐ Bone Density
- ☐ Lab Results
- ☐ AIDS/HIV Information
- ☐ Other: ______________________________________

Purpose of disclosure:

- ☐ Continuing Medical Treatment
- ☐ Residence Relocation
- ☐ Second Opinion
- ☐ Disability Insurance
- ☐ Patient Request
- ☐ Life Insurance
- ☐ FMLA
- ☐ Other: ______________________

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 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 re-disclosed 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:** ____________________
(Guardian or legal representative)