

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, 4600 Hale Parkway, Suite 400, Denver, Colorado 80220 FAX 303-861-7211

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)