AUTHORIZATION FOR THE
USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

RELEASE INFORMATION

1. Name: _____ **DOB** _____

2. I request/authorize you to furnish the indicated person/agency with copies of my (initial all that apply)

__ Outpatient Medical Records __ Inpatient Medical Records
__ Mental Health Records __ OB/GYN Records
__ Other _____

Requesting Records FROM ***circle the provider(s) you wish to release records***	**Send Records TO**
The Family Practice Dr. Christopher Phillips, PhD 6005 Delmonico Dr Ste 150 Colorado Springs, CO 80919 (phone) 719-266-5244 (fax) 719-266-5245	Provider Address Fax # Phone #

3. Information requested will be used for the following purpose (initial all that apply)**:**

__ Further Medical Care __ Retirement
__ Personal Copy __ Other (specify) _____

4. Expiration (please initial)

__ I understand this request will expire in one year unless I specify otherwise.

5. Litigation (initial in the line that applies)

__ I am not party to any pending or contemplated litigation.
__ I am party to pending or contemplated litigation (state to what effect)
_____

6. I understand that my records may contain information regarding the following and I consent to release that information if it is in my record: (*please initial next to each*)

_____ Drug and Alcohol abuse _____ STD/ HIV/ AIDs _____ Mental health illness

7. Initial Each of the Following:

__ I understand that if the person or entity that receives the information is not a health care professional or health plan covered by the federal privacy regulations, the information described may be re-disclosed and no longer protected by those regulations.
__ (If applicable) I understand that **THE FAMILY PRACTICE** will receive compensation for its use and disclosure of the information.
__ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information use/disclosed under this authorization.
__ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on the authorization.

Phone: _____ **Date:** _____
Signature (patient/authorized person)**:** _____
Relationship: _____
Witness: _____ **Date:** _____