

**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	Receiving records
Provider Address Fax # Phone #	The Family Practice 6005 Delmonico Dr Ste 150 Colorado Springs, CO 80919 (fax) 719-266-5245 (phone) 719-266-5244

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

9. 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:** _____