AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
Records Release Form

I authorize _____to RELEASE health information on the following individual:
Patient Name:_____Birthdate:___/___/__
Address:_____
City:_____State:_____Zip:_____
Phone#:_____SSN:_____

Provider Name:_____
Address:_____
City:_____State:_____Zip:_____
Phone#:_____**Fax:**_____

I authorize the information to be DISCLOSED to the following individual or organization:
Name: The Colorado Women's Health Center
Address: 130 Rampart Way suite 150
City: Denver State: CO Zip: 80230

Phone #: (303)366-3388 Fax #: (303)366-3377

Information to be disclosed: (Specify dates where appropriate)
__All Medical Records __ Notes/Summaries __Op/Procedure Reports
__Pathology __PAP/HPV Type __Mammogram/Sonogram
__Bone Density __Lab Results __AIDS/HIV Information
__Other:_____

Purpose of Disclosure:
__Continuing Medical Tx __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. Therefore, I release Consultants in Ob/Gyn from all liability arising from this disclosure of my health information.

By signing this agreement, I acknowledge that I have carefully read, understand and agree to the above terms and conditions.

Printed Name of Patient:_____**Birthdate:___/___/____**

Patient Signature:_____**Date:___/___/_____**