

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION
Records Release Form**

The physicians of The Colorado Women's Health Center, a division of OB/GYN Affiliates ("OBGA ")

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)

| | | |
|--|--|---|
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Notes/Summaries | <input type="checkbox"/> Op/Procedure Reports |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> PAP/HPV Type | <input type="checkbox"/> Mammogram/Sonogram |
| <input type="checkbox"/> Bone Density | <input type="checkbox"/> Lab Results | <input type="checkbox"/> AIDS/HIV Information |
| <input type="checkbox"/> Other: _____ | | |

Purpose of Disclosure:

| | | |
|--|---|---|
| <input type="checkbox"/> Continuing Medical Tx | <input type="checkbox"/> Residence Relocation | <input type="checkbox"/> Second Opinion |
| <input type="checkbox"/> Disability Insurance | <input type="checkbox"/> Patient Request | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> FMLA | <input type="checkbox"/> 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:** ___/___/___