



phone: 720.898.1110 | fax: 720.898.1113  
www.sfmcolorado.com

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone #: \_\_\_\_\_

PLEASE OBTAIN INFORMATION FROM:

PLEASE SEND INFORMATION TO:

\_\_\_\_\_  
Name of Provider/Clinic/Organization

\_\_\_\_\_  
Name of Provider/Clinic/Organization

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I AUTHORIZE the following information to be disclosed: (Please initial all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Entire Record       | <input type="checkbox"/> HIV Record                | <input type="checkbox"/> Billing Records |
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> STD Record                | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Lab Test            | <input type="checkbox"/> Psychiatric/Mental Health | <input type="checkbox"/> Date (s)        |
| <input type="checkbox"/> TB Test             | <input type="checkbox"/> Alcohol/Substance Use     | _____                                    |

REASON for disclosure of health information: (Please initial)

- |  |                                    |                                |
|--|------------------------------------|--------------------------------|
| <input type="checkbox"/> At my request   | <input type="checkbox"/> Job       | <input type="checkbox"/> Other |
| <input type="checkbox"/> Continuing Care | <input type="checkbox"/> School    |                                |
| <input type="checkbox"/> Legal           | <input type="checkbox"/> Insurance |                                |

EXPIRATION of this Authorization: (Please initial one)

- |   |  |
|---|--|
| <input type="checkbox"/> 90 days after signature date | <input type="checkbox"/> On this date: |
| <input type="checkbox"/> When this event happens:     | _____                                  |

ADDITIONAL PATIENT INFORMATION:

- I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
- I understand that I have the right to withdraw this authorization. To withdraw, please sign below.\*
- I understand that I do not have to sign this authorization to get treatment.
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is no longer protected.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

\_\_\_\_\_  
Patient Signature (Parent or Legal Representative, if applicable)

\_\_\_\_\_  
Date:

\_\_\_\_\_  
\* I wish to withdraw this authorization

\_\_\_\_\_  
Date:

- Pick up records     Mail Records     FAX Records