



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