Columbine Family Practice, P.C.

AUTHORIZATION FOR RELEASE OF INCOMING MEDICAL INFORMATION

_____ _____
(Print **patient's** full name) Birth date (Mo/Day/Yr)

_____ _____
(Street address) Social Security Number

_____ _____
(City, state, zip code) Phone (Home)

At the request of the individual, I _____, do hereby authorize _____
(Patient's name) (Site name)
_____to release: Address: _____

_____

Telephone/Fax numbers: _____

_____DISCHARGE SUMMARY _____PATHOLOGY REPORTS _____EMERGENCY REPORTS
_____HISTORY & PHYSICAL _____LABORATORY REPORTS _____OTHER_____
_____PROGRESS NOTES _____RADIOLOGY REPORTS _____
_____OPERATIVE NOTES _____ECG/EEG/CARDIC CATH _____

_____ I do ____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: Columbine Family Practice, P.C.
7335 South Pierce Street
Littleton, CO 80128
Phone: 303-979-7200
Fax: 303-933-5265

PURPOSE OF DISCLOSURE:
_____REFERRAL TO SPECIALIST _____INSURANCE _____WORKERS COMP _____CHANGE OF DOCTOR
_____LEGAL INVESTIGATION _____DISABILITY DETERMINATION _____PERSONAL

OTHER (SPECIFY)_____

Please provide DAYTIME telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for __ months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual (or Guardian or Personal Representative of patient's estate) **Date**

Dks 5/19/08

Reviewed By: _____ (CFP employee signature)