AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is to confirm your authorization to use or disclose your Protected Health Information for a special purpose.

REQUEST FROM:

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____

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Phone: ____________________

Fax: ____________________

SEND TO:

Rocky Mountain Youth - Thornton
9197 Grant St, Suite 200
Thornton, CO 80229
Phone: 303-450-3690
Fax: 303-450-3699

PATIENT NAME: ____________________________ DOB: __________________

Information to be released:

__Entire Record __Medical History __IZ Record __Consultations __ER Report

__Discharge Summary __Radiology Report __Lab Report __Surgical Records

__Specific Dates Needed: ______________________________________

Reason for Disclosure:

__Physician Change __Additional Medical Care __Insurance/Eligibility

__Other (Specify) ____

I certify that this request has been made voluntarily and that the information given above is accurate. I understand that this consent may be revoked at any time, with the exception that disclosure of information has already occurred prior to the receipt of the revocation by the above named provider. If written revocation is not received, the authorization will be considered valid for a period of time not to exceed 90 days from the date of signing.

Individual Patient's Signature:
I have read and agreed with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the Protected Health Information described in this form with the people and/or organization named in this form.

Signature: ____________________________________ Date: ________________

Relationship to Patient: ____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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Fax: 303-450-3699

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