AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____DOB: _____Phone #:_____

PLEASE **OBTAIN** INFORMATION **FROM**:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____
Phone: Fax:

PLEASE **SEND** INFORMATION **TO**:

Mark W. Hinman, M.D., L.L.C.
1350 Tulip Street
Longmont, CO 80501

Phone: 303-776-6872 Fax: 303-776-2501

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

___Immunizations ___Lab Results ___Last 3 Years of Record
___Entire Medical Record ___X-Ray Results ___HIV/AIDS Information
___Other_____

_____

REASON for disclosure of health Information: (Please **Initial** all that apply)

___At my request ___Employment ___Other_____
___Continuity of Care ___School _____
___Legal ___Insurance

ADDITIONAL PATIENT INFORMATION:

- I understand that the medical information released by this authorization may include treatment of physical and mental illness, alcohol/drug abuse and past medical history.
- 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 also understand that revocation will not apply to information that has already been released as specified by this authorization..
- I understand that any disclosure of information carries the potential for re-disclosure and will no longer be protected by federal confidentiality rules.

PLEASE: ___Fax my records ___Mail my records ___Call me to pick up records

_____ _____
Patient Signature(Parent or Legal Representative, if applicable) Relationship/Authority Date

*This authorization will expire one year from the date of signing, or if I am a minor, on the date I become an adult according to state law.