Authorization for Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Maiden/Previous Names: _____

Full Address:

_____

Phone Number: _____

Instructions: Fill out each section of the form in its entirety. Failure to do so may delay processing of your request.

Release Information From:

Name/Facility:

_____

Address:

_____

City, State, Zip:

_____

Phone & Fax:

_____

Release Information To:

Name/Facility:
Ballen Medical

Address:
6081 S. Quebec St., Ste 100

City, State, Zip:
Centennial, CO 80111

Phone & Fax:
720-222-0550 Fax: 720-496-4948

Purpose of Release:

☐ Continuing Medical Care ☐ Work Comp ☐ Disability Determination ☐ Personal

☐ Insurance Claim ☐ Application for Insurance ☐ Other: _____

Delivery Method: **Date information desired by:** _____

Release Format (Check 1 option only):

☐ Paper via ☐ Mail **OR** ☐ Pick Up **OR** ☐ Fax *(as appropriate)* **Fax #:**

Information to be Released:

Service Dates: From: _____ To: _____ **OR** ☐ all future records until this authorization expires

NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)*.

☐ Discharge Summary ☐ ER Records ☐ History & Physical ☐ Clinic Visit Notes

☐ Psychological Evals/Assessments FOR THIS REQUEST I AUTHORIZE RELEASE OF ANY ALCOHOL OR DRUG TREATMENT RECORDS

☐ EKG/Cardiology Reports ☐ Immunization Records ☐ UNLESS Operative Reports INDICATED BELOW:

☐ Lab / Pathology Reports ☐ Radiology Images ☐ Radiology reports ☐ Entire Medical Record

☐ Billing Statements (charges may apply)

☐ Alcohol/Drug Treatment Records _____

☐ Other: _____

I AUTHORIZE RELEASE OF ALL ALCOHOL AND / OR DRUG TREATMENT RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED BELOW:

_____ Do not release alcohol or drug treatment records protected under federal law.

I may revoke this authorization at any time by sending written notice to the facility/provider releasing records. A revocation is not valid if (1) action was previously taken in reliance on this authorization, or (2) if this authorization was obtained as a condition for obtaining insurance coverage. I authorize the facility/provider to disclose medical information to the party identified in the "Release Information To" section. I understand this may include information regarding mental health, alcohol/drug use, and HIV treatment. I understand that once disclosed, information may be redisclosed by the recipient and no longer protected. I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or my eligibility for benefits.

Signature *(required)* **Date Signed** (required)