

# 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.

<b>Release Information From:</b>  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	<b>Release Information To:</b>  Name/Facility: _____ Address: _____ City, State, Zip: _____ Phone & Fax: _____
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**Purpose of Release:**

<input type="checkbox"/> Continuing Medical Care	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Personal
<input type="checkbox"/> Insurance Claim	<input type="checkbox"/> Application for Insurance	<input type="checkbox"/> Other: _____	

**Delivery Method:** Date information desired by: \_\_\_\_\_

<b>Release Format (Check 1 option only):</b> <input type="checkbox"/> Paper via <input type="checkbox"/> Mail <b>OR</b> <input type="checkbox"/> Pick Up <b>OR</b> <input type="checkbox"/> Fax (as appropriate) Fax #: _____
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## Information to be Released:

Service Dates: From: _____ To: _____ <b>OR</b> <input type="checkbox"/> all future records until this authorization expires
<b>NOTE: This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here:</b> _____
<input type="checkbox"/> Abstract (history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe).
<input type="checkbox"/> Discharge Summary <input type="checkbox"/> ER Records <input type="checkbox"/> History & Physical <input type="checkbox"/> Clinic Visit Notes
<input type="checkbox"/> Psychological Evals/Assessments <b>FOR THIS REQUEST I AUTHORIZE RELEASE OF ANY ALCOHOL OR DRUG TREATMENT RECORDS</b>
<input type="checkbox"/> EKG/Cardiology Reports <input type="checkbox"/> Immunization Records <input type="checkbox"/> <u>UNLESS</u> Operative Reports INDICATED BELOW:
<input type="checkbox"/> Lab / Pathology Reports <input type="checkbox"/> Radiology Images <input type="checkbox"/> Radiology reports <input type="checkbox"/> Entire Medical Record
<input type="checkbox"/> Billing Statements (charges may apply)
<input type="checkbox"/> Alcohol/Drug Treatment Records _____
<input type="checkbox"/> 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) _____
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