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**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

I authorize the use or disclosure of health information about me as described below:

The following individual or organization is authorized to disclose the information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following individual or organization is authorized to receive the information:

Provider (optional): \_\_\_\_\_

9195 Grant Street, Ste 410  
Thornton, CO 80229  
Phone: 303-280-2229(BABY)  
Fax: 303-280-0765

300 Exempla Circle, Ste 470  
Lafayette, CO 80026  
303-665-6016  
303-665-0121

6363 West 120<sup>th</sup> Avenue, Ste 300  
Broomfield, CO 80020  
303-460-7116  
303-460-8204

The information will be disclosed for the following purposes:

\_\_\_\_\_

The information to be disclosed:

- Specific condition(s) \_\_\_\_\_  Specific dates of treatment \_\_\_\_\_
- Tests/Lab results only \_\_\_\_\_  Other \_\_\_\_\_
- All medical records generated by this provider

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and substance abuse.

Re disclosure: I understand that any disclosure of information carries with it the potential for re disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Expiration: This authorization will expire on \_\_\_\_\_ (date, event, or condition).

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Maiden/Other Names Used

\_\_\_\_\_  
SS#

\_\_\_\_\_  
Name of Personal Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient