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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:

KimberLee Barnes, M.D.
Colleen Begley, M.D.
Michael Gottlieb, M.D.
Cindy Long, M.D.
Melinda Sharkey, P.A.-C.

of

The Women's Health Group, PLLC
6363 W. 120th Avenue, Suite 202
Broomfield, CO 80020
Phone: (303)460-7116
Fax: (303)460-8204

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

Name: ____

Address: ____

City, State, ZipCode: ____

Fax: ____

Phone: ____

What is the reason you are transferring care? ____

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