RELEASE OF INFORMATION AUTHORIZATION FORM

To: ____ (Name and address of medical provider or facility)
____
____
____

Patient name: ____ Date of birth: ____________________

Previous name: ____ Social Security No: _______________

I. <u>My Authorization:</u>

You may disclose the following health care information (check all that apply):

__ All my health information maintained by the above named practice or facility
(Circle include or exclude for each of the following)

Include **OR** Exclude: My health information related to drug abuse
Include **OR** Exclude: My health information related to alcohol abuse
Include **OR** Exclude: My health information related to HIV/AIDS
Include **OR** Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

__ My health information relating to the following treatment or condition: ____________________________
__ My health information for the date(s): ____
__ Other: ____

Disclose this health information to:

Patient Physician Relations Committee
Denver Medical Society
1850 Williams Street
Denver, CO 80218

(contact Number: (303) 377-1850)

This authorization is being provided for the purpose of review and resolution of a pending grievance.

This authorization ends: __ on (date) ____________________
__ when the following event occurs – at the conclusion of the grievance review

II. <u>My Rights</u>

This authorization is voluntary. I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I am entitled to a copy of this authorization.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

____ ____________________ __________________
Patient or legally authorized individual signature Date Time

____ ____
Printed Name if signed on behalf of a patient Relationship (parent, legal guardian, personal representative, etc)

Ppr/release.doc