



Douglas Family Medicine, PC

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Patient Authorization to Disclose Protected Health Information

Patient Name

Date of Birth

Phone

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, agency or patient named.

Release FROM Facility:		Release TO Facility:	Douglas Family Medicine Dr. Hallmark, Dr. Odekirk, Evelyn (Missy) Sdrulla PA
Address:		Address:	1189 S. Perry St Suite 230 Castle Rock, CO 80104
Phone:		Phone:	303-688-3434
Fax:		Fax:	303-688-4454

Records to be included:

- Imaging
 Medication Records
 Progress Notes
 Lab results
 Psych/Mental Health
 Entire Record

Specific Dates of treatment:

Authorization: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by submitting my request in writing to the designated medical records department. If I have authorized the disclosure of my health information to someone who is not legally required to keep it private, it may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee may be charged for copies of my medical record. Expiration: Without my express revocation, this authorization will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 90 days from the date hereof, unless a different date is specified. Acknowledgement: I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV.

Patient Signature (Parent or Legal Guardian)

Date

Office Use:

Number of pages released:

Completion Date:

Delivery Method: