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

Records to be included:

- ☐ Imaging
- ☐ Lab results
- ☐ Medication Records
- ☐ Psych/Mental Health
- ☐ Progress Notes
- ☐ 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: _____