



AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City/State/Zip: _____ Phone Number: _____

I AUTHORIZE MY MEDICAL RECORDS BE RELEASED FROM:

Westmed Family Healthcare
12201 Pecos Street, Suite 500
Westminster, CO 80234
(P) 303-457-4497 (F) 303-254-4369

I AUTHORIZE MY MEDICAL RECORDS BE RELEASED TO:

Doctor's Office, Hospital, Clinic, etc.:

Address/City/State/Zip

Phone Number: _____ Fax Number: _____

For the purpose of: Continuity of Care OR Other: _____

Westmed Family Healthcare will release the three most recent progress notes and the current medication list we have on file.

1. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
2. I understand this authorization will expire, without my express revocation, one year from the date of the signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
3. I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents is \$18.53 for the first ten pages, \$.85 per page for pages 11 through 40 and \$.57 per page for each page over 40.

Signature of Patient or Authorized Personal Representative

Date

PRINT Name of Patient or Representative