Family Practice Associates PC.

433 Summit Blvd Suite 201

Broomfield, CO. 20021

Phone: 303-673-9090 Fax: 303-673-9195

Authorization for Disclosure of Health Information

Patient Name:____ DOB:_________________________

PREVIOUS PROVIDER:

____

PHONE: ____________________**FAX;**____________________

I authorize the use or disclosure of the above-named individual health information as described below:

To: **Family Practice Associates PC.**
433 Summit Blvd Suite 201
Broomfield, CO. 80021

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_______ Complete Health Record
_______ Physical Exam
_______ Immunizations Records
_______ Communicable Disease Records (STD)
_______ Other (Please specify) ____
_______Lab results/ X-rays Reports
_______Progress Notes
_______ Drug and Alcohol Records
_______Behavioral and Mental Health Records

This information may be used by the following individual or organization.

Purpose of Release: ____

Date information is needed: ______________________________

Release method/Format requested (check one)

_____Fax _______Paper **Please, no CD's or digital records**

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here__________. This authorization may be cancelled in writing at any time. A cancellation will not change releases that happened before the cancellation. Family Practice Associates, PC, will not restrict treatment if I choose to not to sign this authorization.

A photocopy/fax of this authorization will be treated in the same way as the original. Family Practice Associates, PC, records may include records that were received from other organizations. If these records have been used by Family Practice Associates, PC, and filed in the records Family Practice Associates, PC, maintains for you, these records may be released with your Family Practice Associates, PC, records. Family Practice Associates, PC, cannot prevent redisclosure of your information by person or organization who received your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released.

By signing this authorization, you release Family Practice Associates, PC, from all liability resulting from redisclosure by the recipient.

Your signature indicates that you have read and understand this form and authorize release of your information as described above.

____

Patient/Legal Guardian Signature Date Authority to act on behalf of patient (attach document).