

**THE PEDIATRIC CENTER**

Francesco Beuf, M.D. Dina Brudenell, M.D. Eben Carsey, M.D. Jill Kamon, M.D. Diana Tanney, M.D.  
4745 Arapahoe Ave., Suite 310, Boulder, CO 80303 Phone: 303-442-2913 Fax: 303-442-7635

**AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize		
_____	name of hospital, physician or health care provider	
to use and/or disclose my health information to:		
_____	name of individual, organization, etc.	
_____	address	City
State	Zip	

**REASON FOR THIS AUTHORIZATION** (check all that apply)

- at my request
- other (specify) \_\_\_\_\_

**PLEASE RELEASE THE FOLLOWING INFORMATION:**

- Immunization Records
- Most Recent Physical Exam
- Complete Clinical Records Produced in this Office
- Complete Clinical Records Produced in this Office and Those Transferred to us from Previous Physicians.

I understand that the information in my health record may include information relating to sexually transmitted disease, or acquired immunodeficiency syndrome (AIDS). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**MY RIGHTS**

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 may not be able to revoke this authorization if its purpose was to obtain insurance.

**REDISCLASURE**

I understand that 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

\_\_\_\_\_  
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, etc.)

This authorization is valid for **90 DAYS** from the date of signature.  
**A COPY OF THE REQUESTING PERSON'S PICTURE ID IS REQUIRED.**

OFFICE USE ONLY
ID checked:
Initials: _____
Date: _____

PLEASE INDICATE IF YOU ARE TRANSFERRING CARE  Yes  No

If so, for what reason

- Moving from area
  - Insurance change
  - Child too old to see a Pediatrician
  - Dissatisfaction – please explain \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_