

THE PEDIATRIC CENTER

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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.

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 _____

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