Specialists in Womne's Care, PC
555 Camino Del Rio, Suite B2
DURANGO, CO 81303
PHONE: 970-259-0701
FAX: 970-259-0109

Revocation
Date Revoked:_____
Initials of Privacy Official

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

NAME OF PATIENT:	DOB:

I, _____ authorize the RELEASE AND/OR DISCLOSURE OF MY MEDICAL INFORMATION as indicated on this form. I understand that treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this release and/or disclosure.

Please **REQUEST** Medical Information **FROM**:

Name:	
Group Name/Title:	
Address:	
Phone:	Fax:

Please **SEND** Medical Information **TO**:

Name:	
Group Name/Title:	
Address:	
Phone:	Fax:

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for two years from the date of signature if no date is entered.

REVOCATION: This authorization may be revoked in writing at any time. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

RE-DISCLOSURE: I understand that the information released by this authorization may be redisclosed by the recipient of these records.

SPECIFIC INFORMATION TO BE RELEASED:
Initial and/or sign next to the type of information that is to be released and/or disclosed:

____ ALL MEDICAL RECORDS
progress notes, consultation requests and reports, test results, radiology results and records received by other health care providers

____ ENTIRE MEDICAL RECORD
all of the above category in addition to telephone messages, pharmacy records, billing records and insurance records

____ OTHER (PLEASE SPECIFY) _____

____ DRUG AND ALCOHOL _____ _____
Signature of Patient or Representative Date

____ HIV RELATED INFORMATION _____ _____
Signature of Patient or Representative Date

____ MENTAL HEALTH _____ _____
Signature of Patient or Representative Date

DATES OF SERVICES REQUESTED FOR RELEASE: _____

REASON FOR THE RELEASE of this information:

____ CHANGING PROVIDERS/REFERRAL
____ AT THE REQUEST OF THE INDIVIDUAL
____ LEGAL ACTION
____ OTHER _____

_____ _____ _____
DATE SIGNATURE OF PATIENT OR REPRESENTATIVE INDICATE RELATIONSHIP OF REPRESENTATIVE

Distribution of copies: Original to patient's Medical Record, copy to patient.