Endocrinology of the Rockies, PC.

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please be sure to complete the form thoroughly. Delays may occur with illegible or incomplete requests.

Patient's Name: _____ Date of Birth: _____

I authorize my physician and staff to disclose the following health information. (Check One):

[ ] Entire Chart
[ ] Specific Information (please specify): _____

Records coming from:

_____
_____
_____
Phone: (____) _____
Fax: (____) _____

Records going to:

_____
_____
_____
Phone: (____) _____
Fax: (____) _____

This protected information is being disclosed and used for the following purpose. (Check One):

[ ] Changing to a new provider
[ ] Continuing Care
[ ] Other (please specify): _____
[ ] At the request of the individual

This authorization shall be in effect for one year or until (date) _____, I understand that I have the right to revoke this authorization, in writing, at any time.

_____
Signature of Patient/Guardian/Representative

_____
Print Name of Patient/Guardian/Representative

_____
Date

_____
Relationship