

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. I authorize _____
Medical provider's name, phone number, fax number

to release the health information of the individual named below:

Patient Name: _____ SSN#: _____

Address: _____

Phone #: _____ Date of Birth: _____

2. I authorize the information to be disclosed to and used by the following organization:

Sunrise Family Practice PLLC
10268 West Centennial Road, Suite 104
Littleton, CO 80127
Phone: 303-738-5808 Fax: 303-738-5810

For the purpose of: _____

3. The type and amount of information to be disclosed is as circled below, dates specified as appropriate:

Entire Medical Record	Laboratory results, from _____ to _____
Most recent 1, 3, 5 years of Record	X-ray results, from _____ to _____
Immunizations	Genetic testing, from _____ to _____
HIV/AIDS information, from _____ to _____	
Entire Medical Record for Diagnosis of _____, from _____ to _____	
Other _____	

**I will pick up ___ Mail to: SFP as above Fax to: SFP as above

4. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
5. I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
6. I understand that the authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization, SFP cannot condition treatment, payment, enrollment in a health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
7. I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations, the fee for copying requested documents is \$14.00 for the first ten pages, \$.50 per page for pages 11-40 and \$.33 per page for each page over 40. Shipping will also be charged. There is no charge for records sent to another health care provider.

X _____
Signature of Patient or Authorized Personal Representative

X _____
Date

Personal Representative's Name and Relationship to patient