SOUTH DENVER ENDOCRINOLOGY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____**Previous Names**: _____ **Birthdate**: _____

(Last, First, Middle Initial)

Address: _____**City**: _____ **State**: _____ **Zip**: _____

I Authorize: South Denver Endocrinology (mailing address: 4950 S Yosemite St #F2-330 Greenwood Village CO 80111)

To Release to:_____

(**Name of Health Facility, Individual, Agency, Etc**)

_____

(**FAX NUMBER**)

_____

(address including city, state, zip)

Information to be released:

☐ All Visit Encounters ☐ Ultrasound Pictures

Term: This Authorization will remain in effect: ☐ Until the Provider fulfills this request.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a 3rd party. The 3rd party may not be required to abide by this Authorization or applicable federal/state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

_____ _____ _____

Printed Name Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____

Name of Guardian/Representative Legal Relationship Date