The Women's Health Group

Authorization to Receive Health Information

Printed Name _____ Date of Birth _____

I authorize the following organization/provider to disclose my health information to The Women's Health Group

Name of individual or organization _____

Phone number _____ Fax number _____

Please fax the information to secure fax: (303) 460-8204

For the purpose of: [ ] Consultation [ ] Records review [ ] Transfer of care

[ ] Other _____

Please disclose the following information;

[ ] Specific condition (s) _____ [ ] Specific dates of care _____

[ ] Tests/Lab results (***Please send actual lab reports***) _____

[ ] Other _____

[ ] All medical records generated by this provider

Sensitive information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency Syndrome (AIDS) or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and substance abuse.

Disclosure: I understand that any disclosure of information carries with it the potential for re disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information already released based on this authorization. This authorization will expire 1 year from the date of this form, or on _____

_____

Signature Date