



400 McCaslin, #103 * Louisville, CO 80027 * Phone (303) 666.7337 * Fax (303) 666.7379

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

Parent Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Fax#: _____

Reason for this authorization:

Immunizations, school, health forms

Transferring to another practice

Other _____

Release info to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

I accept full responsibility of copying fees. Per Colorado Department of Health and Public Environment Regulations, the fee for copying requested documents is \$14.00 for the first ten pages, \$.50 per page for pages 11 through 40, and \$.33 per page for each page over 40. There is no charge for records sent to another healthcare provider of for a copy of immunization record only.

Once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Parent or legally authorized individual signature

Date

Printed name of above signature

Relationship to patient

*Patients 18 years of age and older must sign for their own records.