Authorization to Obtain or Release Medical Information

Please fill out and sign if you have a previous therapist, doctor, or provider who you would like to share relevant information about your past treatment and health.

Patient Name ____ Date of Birth ______________

Address ____

City/State/Zip ____

Phone ______________________________

Parent/Guardian/Requestor Completing This Form (if applicable)___________________________________

RELEASE FROM and TO:

I authorize the following institution or person to release and obtain medical record information from and to Denver Wellness Associates:

Name ____

Address/City/State/Zip____________________________________

Phone ____________________ Fax ________________________

Name ____

Address/City/State/Zip____________________________________

Phone ____________________ Fax ________________________

INFORMATION TO RELEASE

State/Federal Laws require specific authorization to release the following types of information.

Please mark beside the types of information to be released:

_____ Mental Health

_____ Psychotherapy Notes/Labs

_____ Drug/Alcohol Abuse

_____ HIV/AIDS Related

RELEASE MEDICAL INFORMATION FROM and TO:

Denver Wellness Associates
300 South Jackson Street, Suite 240
Denver, Colorado 80209
Phone: 720-724-3668
Fax: 720-598-0480

PATIENT/AUTHORIZED REPRESENTATIVE AUTHORIZATION

I understand that: (1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. (3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose.

Expiration: Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event will expire 365 days from the date hereof.

____ _______________

Signature of Patient (or Patient Representative if Minor) Date