

OnPoint Internal Medicine

AUTHORIZATION FOR RELEASE OF INCOMING MEDICAL INFORMATION

(Print **patient's** full name)

Birth date (Mo/Day/Yr)

(Street address)

Social Security Number

(City, state, zip code)

Phone (Home)

At the request of the individual, I _____, do hereby authorize _____
(Patient's name) (Site name)
_____ to release: Address: _____

Telephone/Fax numbers: _____

_____ DISCHARGE SUMMARY	_____ PATHOLOGY REPORTS	_____ EMERGENCY REPORTS
_____ HISTORY & PHYSICAL	_____ LABORATORY REPORTS	_____ OTHER _____
_____ PROGRESS NOTES	_____ RADIOLOGY REPORTS	_____
_____ OPERATIVE NOTES	_____ ECG/EEG/CARDIAC CATH	_____

_____ I do _____ I do **NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

INFORMATION RELEASE TO: OnPoint Internal Medicine
850 East Harvard Avenue
Suite 405 (Harvard Park West Building),
Denver, CO 80210
Phone: (303) 584-8900, Fax: (303) 584-0525

PURPOSE OF DISCLOSURE:
_____ REFERRAL TO SPECIALIST _____ INSURANCE _____ WORKERS COMP _____ CHANGE OF DOCTOR
_____ LEGAL INVESTIGATION _____ DISABILITY DETERMINATION _____ PERSONAL

OTHER (SPECIFY) _____

Please provide DAYTIME telephone number in the event we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for ___ months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

Signature of individual (or Guardian or Personal Representative of patient's estate)

Date

Reviewed By: _____ (Employee signature)