Authorization to disclose Health Information

Medical facility records are requested from:	Medical facility disclosed to:
Facility Name: _____ Facility Phone: _____ Facility Fax: _____	Sapphire Pediatrics 4500 E. 9th Ave. Suite 300 Denver, CO 80220 P: 720-941-1778 F: 720-941-1783

I authorize the disclosure of Health Information for the following individual:

Patient Name: _____

Patient DOB: _____ Patient Phone: _____

The type of information to disclose is as follows:

☐ Most recent 3 years of records ☐ Behavioral health

☐ Laboratory and radiology ☐ Entire medical record

The purpose of this release of medical information is:

☐ Continuation of care ☐ Other _____

I, _____, understand that authorization for disclosure of health information is voluntary and I can refuse to sign this authorization. I understand that any disclosure of health information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

_____

Parent / Guardian Signature Date

Note: Medical office records may include disclosure of information related to mental health, alcohol / drug use, and HIV references as part of this authorization.

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here: _____/_____/_____.

Revocation: Patient or parent/guardian can revoke this authorization upon a written request. If you revoke, it will not affect information disclosed before the receipt of the written request.

Re-disclosure: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA).