Authorization for Release of Medical Record Information

Patient name: _____

Date of birth: _____

Phone (home): (_____) _____-_____ Phone (work): (_____) _____-_____

Address: _____

City/State/Zip: _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility name: Mint Health Clinics Lone Tree

Facility phone: 720.409.3133

Facility address: 10099 RidgeGate Parkway, #210

Facility City/State/Zip : Lone Tree, CO 80124

Dates and type of information to disclose:	The purpose of disclosure is:
[ ] Two (2) years prior from last date seen	[ ] Change of insurance or physician
[ ] Dates other: _____	[ ] Continuation of care
[ ] Specific information requested:	[ ] Referral
_____	[ ] Other: _____
_____	_____
_____	_____

RESTRICTIONS: Only medical records originated through the healthcare facility listed above will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release to: _____

Address: _____

City/State/Zip: _____

Fax: _____ [ ] Please mail records

Phone: _____ [ ] Please fax records

I have read the above foregoing authorization and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____
Signature of Patient / Parent / Guardian / Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status)

_____
Date

_____ _____
Printed name of Authorized Representative Relationship / Capacity to Patient

_____
Address and telephone number of Authorized Representative