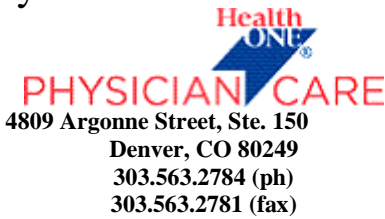


Aspen Family Medicine at Green Valley Ranch



Authorization/Release For Use And Disclosure For Protected Health Information (PHI)

Patient Name: _____ DOB: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

For Disclosure Only: I hereby authorize the disclosure of the following Protected Health Information (PHI) of the patient listed above for the purpose of primary follow-up care.

To From

Aspen Family Medicine Green Valley Ranch 4809 Argonne Street, Ste: 150 Denver, Co. 80249

To / From _____

PH: _____ Fax: _____

For Treatment Dates: _____

Are you transferring care to another provider? Yes No

Type of Access Required: Copies of the Record Inspection of the Record

Selected Portions of Protected Health Information (PHI):

- Entire Record Lab Progress Notes Emergency Room Imaging/Radiology Physicians Orders
- History/Physical Cardiac Studies Billing Records Consult Report Demographics
- Internal Marketing Operative Reports Nursing Notes Verbal Communications
- Rehabilitation/ PT Medication Logs Other: _____

Expiration: This Authorization Will Expire: Fulfillment of this Request OR Date: _____

1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing/results, or AIDS information. _____ (Initial)
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the Protected Health Information (PHI) as stated.

Signature of Patient/Guardian: _____

Relation to Patient: _____ Date: _____