# Aspen Family Medicine at Green Valley Ranch

**4809 Argonne Street, Ste. 150**
**Denver, CO 80249**
**303.563.2784 (ph)**
**303.563.2781 (fax)**

**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**<br>**Green Valley Ranch**<br>**4809 Argonne Street, Ste: 150**<br>**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:_____**