Dr. Shelley Meyer, D.O., R.D., C.L.T.
Sarah Julianelle, F.N.P.-BC
Molly Dockhorn, M.S., R.D., C.L.T.

3729 W 32nd Avenue
Denver, Colorado 80211
P: (303) 916-1064

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name:_____

Address:_____

Street City State Zip

Work Phone:_____ Home Phone:_____ Fax:_____

Birthdate:_____

Medical Information Requested To: (Name, Address, Phone, Fax)

_____

_____

_____

_____

Medical Information Released From:

Dr. Shelley Meyer
Highlands Health and Wellness

3729 W 32nd Avenue
Denver, CO 80211
Phone: (303) 916-1064
Fax: (720) 439-8839

Information Requested:

___Discharge Summary ___History & Physical ___Consultations ___Emergency Room Report

___Pathology Reports ___Radiology Reports ___Surgical Reports ___Laboratory Reports

___Psychological/Psychiatric Evaluations ___Complete Record

___Other:_____

Treatment Date(s):_____

Purpose of disclosure/Reason for information request:_____

I understand that the information to be disclosed may include any or all information involving communicable or venereal disease, psychological or psychiatric conditions, drug or alcohol abuse and/or alcoholism. It may also include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency viruses (HIV), also known as acquired immune deficiency syndrome (AIDS). (Protected by State law).

AUTHORIZATION: I certify that this request is made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing by sending a letter to the facility Privacy Officer or their designee.I understand my revocation will not be effective to the extent that action has already been taken in reliance on it. This authorization expires 180 days (6 months) from the date of signing. I have authorized the disclosure of my health information to someone who is not legally required to keep it private. It may be re-disclosed and may no longer be protected. A copy or fax of this authorization will be as valid as the original. I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility to obtain benefits. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand a fee will be charged for copies of my medical record. I understand the facility will provide me a copy of the signed authorization form upon request. If I have questions about disclosure of my health information I can contact the facility Privacy Officer or their designee.

Signature:_____Date:_____

Patient (Parent or Guardian, if patient is a minor)

If patient is unable to sign, please document reason_____

Minor's signature is required for release of any records for treatment, which the minor may authorize under Colorado Law.

Relation to patient:_____