



**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION**

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

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Birthdate: \_\_\_\_\_

**Medical Information Released To:**

Dr. Shelley Meyer  
Highlands Health and Wellness

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

**Medical Information Requested From:  
(Name, Address, Phone, Fax)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_