CHAFFEE FAMILY PHYSICIANS

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I voluntarily authorize Chaffee Family Physicians to release the health information of the individual named below:

Patient Name:_____
Address:_____
Phone:_____DOB:_____SSN:_____

I voluntarily authorize the information to be disclosed to and used by the following individual or organization

TO____ FROM____

Name:_____
Address:_____
Phone:_____Fax:_____

The type of information to disclose is as follows:

___Immunizations
___Laboratory
___Entire Medical Record
___HIV/AIDS information
___Mental Health
___Most Recent 3 years of records
___X-ray
___Diagnostic Testing
___Other
Expiration Date_____

I understand that I may revoke this authorization at any time. I understand that I must revoke this in writing. I understand by revoking this authorization it will not apply to any medical information already released. I understand this however will not apply to my insurance company, when the law provides my insurer with the right to contest a claim under my policy. I understand according to CO state statutes (GCCR 1101-1, Rule XIV) there is a charge for medical records. The charge is $14.00 for the first 10 pages, .50/pgs 10-39 and .33/pgs 40 and above. I release the above named from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure.

Signature of Patient/or legal guardian_____Date_____