

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described below:

The following individual or organization is authorized to disclose the information:

The following individual or organization is authorized to receive the information:

- | | | |
|---|----|--------------------------------|
| <input type="checkbox"/> Stephen Volin, M.D. | | The Women's Health Group, P.C. |
| <input type="checkbox"/> Vernon Naake, M.D. | | 9195 Grant Street, Suite 410 |
| <input type="checkbox"/> Cindy Long, M.D. | of | Thornton, CO 80229 |
| <input type="checkbox"/> Kathryn Hoch, M.D. | | Phone (303) 280-2229 |
| <input type="checkbox"/> Dionne Gallagher, M.D. | | Fax (303) 280-0765 |
| <input type="checkbox"/> Kristin Head, M.D. | | |
| <input type="checkbox"/> Stacey Hennesy, M.D. | | |

The information will be disclosed for the following purposes: _____

The information to be disclosed:

- Specific condition(s) _____ Specific dates of treatment _____
 Tests/Lab results only _____ Other _____
 All medical records generated by this provider

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and substance abuse.

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Expiration: This authorization will expire on _____ (date, event, or condition).

Signature of Patient or Representative

Date

Patient Name

Date of Birth

Maiden/Other Names Used

SS#

Name of Personal Representative (if applicable)

Relationship to Patient