



**ELDORADO FAMILY MEDICINE CLINIC**

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to  
(Person Signing Authorization) (Healthcare Provider/Medical Facility)

furnish the following medical information to \_\_\_\_\_  
(Name of Receiving Party)

Purpose of disclosure:  Continuation of care  Personal use  Other: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

**Specific information to be released:** Date(s) of Service: \_\_\_\_\_

- Complete Medical Record  Pathology Report  Progress Notes
- History and Physical  Laboratory Reports  Discharge Summary
- Emergency Room Report  Radiology Reports  Operative Report
- Consultation Report  Respiratory Reports  Other \_\_\_\_\_

I understand that this authorization includes disclosing information regarding mental health, developmental disability, sexually transmitted disease, alcohol and/or drug abuse services, and HIV/AIDS test results, including but not limited to examination, diagnosis, evaluation, treatment or rehabilitation.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. If I fail to specify an expiration date, event or condition, this authorization will **expire in 6 months**.

I understand that the information that is being disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected under the Health Insurance Portability Accountability Act.

I agree that a photocopy of this authorization is as valid as the original.

Signed: **X** \_\_\_\_\_ Date: **X** \_\_\_\_\_  
(Patient/Representative)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
(Clinic Employee/Witness)

***"Healthcare Built On Excellence"***