brighton pediatrics

GET ON BOARD FOR WELLNESS

183 S. 18th Ave

Brighton, CO 80601

Phone: 303-659-4248

Fax: 303-659-4283

AUTHORIZATION TO RELEASE/RECEIVE PATIENT HEALTH INFORMATION

Patient's Legal Name: _____

Date of birth: _____ Gender: _____

Address: _____

City/State/Zip_____

Home Phone: _____ Cell Phone: _____

A) I hereby authorize/request information FROM

NAME: _____

ADDRESS:

_____

_____

PHONE NUMBER: _____

FAX NUMBER: _____

B) To be released TO:

NAME: _____

ADDRESS:

_____

_____

PHONE NUMBER: _____

FAX NUMBER: _____

This disclosure can be used for the following purpose(s)

- o Insurance
- o Medical Treatment
- o Medical Condition Verification
- o Disability
- o FMLA
- o Workers Comp
- o Personal
- o Transferring Care
- o Verbal communication between the two entities listed above
- o Other:

  _____

Please indicate the type of information you authorize for release:

Date Range: _____to_____

****No more than THREE years unless requested by a physician or attorney****

- o Only copies of Immunization Record, Growth Charts, last Physical or Well Baby exam.
- o My health information relating to the following treatment or condition _____
- o All my health information maintained by the above practice. ***(Not including confidential information like behavioral health records and substance use records. To include please check those boxes as well.)***
- o Behavioral Health Records
- o Substance Use Records

My Rights I understand I do not have to sign this authorization to get health care benefits from Brighton Pediatrics for treatment, payment, or health care operations. However, a signature will be required if I am asked to take part in a research study, for marketing purposes or to receive health care when the purpose is to create health information for a third party. I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that I can revoke this authorization by writing a letter to this office. I understand that once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed Name of patient or legally authorized individual **Relationship (self, parent, legal guardian etc.)**

(Please attach legal documentation of authority of guardianship if applicable)

This authorization ends after 1 year from the date of this form, unless revoked in writing prior to 1 year.