AUTHROIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician or facility to provide records: _____ Phone # _____

Client's Name: _____

Address: _____

Social Security # _____ DOB _____

Records to be received by: **Destiny Internal Medicine**
1550 S Potomac Street, Suite 110
Aurora, CO 80012
Phone: 720-324-4777
Fax: 720-262-4788

I authorize the health care provider to release the information specified below to the organization, agency, or individual name on this request. I specifically authorize the release of information regarding the following condition(s): Please initial

_____ Drug Abuse (if any) **_____ Substance Abuse (if any)**

_____ Psychological or psychiatric conditions (if any) **_____ AIDS/HIV status (if any)**

_____

Release these records: Please initial

1. **Only records generated by this facility (not including the records received from other sources) _____**
2. **Only some portion of records maintained at facility (specify below) _____**
3. **All medical records at the facility _____**

_____

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time.

Use for copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print): **Person authorized to sign for patient:**

_____ **_____**

Patient's signature: **Date:**

_____ **_____**