CHERRY CREEK PEDIATRICS

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Patients 18 Years or Older Authorization to Disclose Protected Health Information

Patient Legal Name _____ Date of Birth _____

Address _____ Phone# _____

City _____ State _____ Zip Code _____

I authorize the following people to receive Protected Health Information:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

I authorize the following protected health information to be disclosed:

- ☐ Well visit chart notes
- ☐ Sick visit chart notes
- ☐ Laboratory results
- ☐ X-Ray reports
- ☐ Medical instructions or advice
- ☐ Prescription drug information
- ☐ Drug abuse
- ☐ Alcohol abuse
- ☐ Sexual activity or HIV/AIDS or STDs
- ☐ Psychological or psychiatric conditions, including psychotherapy notes
- ☐ Other (specify):_____

- I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.
- The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.
- I have read the above and authorize the disclosure of the protected health information.

This release expires 1 year from date of signature.

Print Name of Patient_____

Signature of Patient_____Date_____