

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ **to**
release medical information from the records of:

(Name of Facility)

Patient Name: Tamara Catherine Anderson
SS# 651-01-4405

D.O.B. August 14, 1996

Patient Street Address: 6730 Tullamore Dr,
State: CO **Zip Code:** 80923

City: Colorado Springs

Date(s) of Treatment Requested: _____

Information to be disclosed (check all applicable items to be released):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Record | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> X-Rays Reports | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Commitment Papers |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Doctor's Orders | <input type="checkbox"/> HIV Testing |
| <input type="checkbox"/> Consultations | <input type="checkbox"/> EKG/ECG Tests | <input type="checkbox"/> Nurse's Notes | |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Therapy Notes | | |
| <input type="checkbox"/> Other (please specify): _____ | | | |

Purpose Or Need For the Disclosure Is:

- ☐ Continued Medical Care ☐ Insurance ☒ Legal ☐ Patient's Own Use ☐ Other _____

The Information May Be Disclosed To:

Ramos Law
 10190 Bannock St., Suite 200
 Northglenn, CO 80260
 PH: (303) 733-6353
 FX: (303) 865-5666

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, and enrollment in a health plan or my eligibility for health care benefits. However, information will not be released to the above-indicated recipient without my signature.

I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law.

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

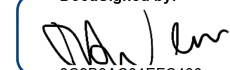
This authorization expires on: _____ or upon the following event: CASE SETTLEMENT

(Date)

(If no date is specified, this authorization will expire in six months from the date of signature).

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

Decided by


8C9B0AC01EFC408
 (Signature of Patient or Personal Representative*)

(Date of Signature)

* If signed by a personal representative, a description of the representative's authority to act is as follows:

- | | | |
|--|---|---|
| <input type="checkbox"/> Parent | <input type="checkbox"/> Legal Guardian | <input type="checkbox"/> Health Care Power of Attorney |
| <input type="checkbox"/> Administrator | <input type="checkbox"/> Executor of Estate | <input type="checkbox"/> Next of Kin <input type="checkbox"/> Beneficiary |