



Youth Clinic

1200 E Elizabeth Street ~ Fort Collins, CO 80524 ~ Ph 970.416.6293 ~ Fax 970.416.6299

Authorization for Release of Information

Patient Name _____

LAST FIRST MI MAIDEN / OTHER NAME

Date of Birth _____ Medical Record # _____
(Office Use Only)

Address _____ City _____ State _____ Zip _____

Daytime Phone _____ Evening Phone _____

I hereby authorize the release of medical records as indicated below:

Released from:	Released to:
Name _____	Name _____
Address _____	Address _____
_____	_____
Phone _____	Phone _____
Fax _____	Fax _____

Information to be released

- History and physical exam
- Progress notes
- Lab reports
- X-ray reports
- Other: _____

Dates requested

ONLY THE PAST 5 YEARS OF RECORDS ARE PROVIDED UNLESS OTHERWISE REQUESTED

I specifically authorize the release of information relating to:

- Substance abuse (including drug and alcohol abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

Signature of Patient, Parent or Legal Guardian Date

Purpose of Disclosure

Is patient transferring out of the practice _____ Yes _____ No

If **yes**, please indicate the reason

- Change of insurance
- Moving out of area
- Family consolidation
- Aged out
- Unhappy with care of service

Name of new insurance carrier _____

If **no**, please indicate the reason

- Specialist
- Consultation / second opinion
- Personal use
- Other (please specify) _____
- Legal
- Insurance request
- Verbal exchange only

PLEASE NOTE - A fee will be charged for records copied for legal, personal and insurance company requests.

(continued)

