Authorization to Disclose Protected Health Information

Name: _____

Address: _____

Date of Birth: _____

Soc. Sec. # _____

I hereby authorize the use and/or disclosure of my protected health information as described in this authorization.

1. Specific person/organization (or class of persons) authorized to provide the information:

2. Specific person/organization (or class of persons) authorized to receive and use the information:

Haddon, Morgan and Foreman, P.C.
150 East 10th Avenue, Denver, Colorado 80203

3. Specific description of the information: Complete medical record from inception of treatment to present, including, but not limited to, all of my office medical records, hospital medical records, patient information sheets, questionnaires, x-rays, other diagnostic studies and laboratory tests, emergency room records, out-patient records, consultation records, therapy records, and all other in-patient or out-patient hospital notes, charts, documents, all personal notes and all billing records.

4. Specific purpose for the use and/or disclosure of the protected health information: At my request in connection with litigation pending in the County District Court.

5. I understand this authorization will expire, without my express revocation, one year from the date of signing, or if I am a minor, on the date I become an adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.

6. I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.

7. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.

8. I understand that I am entitled to receive a copy of this authorization.

9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the above-named medical provider.

10. Photocopies of this authorization are to be given the same effect as the original.

_____ _____

Date