**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

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|  |  |
| Patient Name Date of Birth |  |

Records to be released from: Records to be released to:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  |  | Adam Palazzari, MD, Maura Capaul, FNP,  Heather Dunham, FNP |  |
| Practice Name: |  |  | Lafayette Pediatrics & Internal Medicine |  |
| Address: |  |  | 300 Exempla Circle, Suite 420 |  |
| City, State, Zip: |  |  | Lafayette, CO 80026 |  |
| Phone: |  |  | Phone: 720-565-6101 |  |
| Fax: |  |  | Fax: 833-918-2235 |  |

This request and authorization applies to:

* All healthcare information
* Healthcare information relating to the following condition, treatment, dates:

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* Other:

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* I authorize the release of any records regarding drug, alcohol, or mental health treatment to the above named practice/person.
* I authorize any information concerning Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) in my medical records to be released to the above named practice/person.
* I understand that my records are protected under federal regulations, including HIPPA and 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that the recipient of this information may in some circumstances re-disclose it and the information may then no longer be protected by HIPPA. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

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| Print Name of Patient/Guardian | Signature of Patient/Guardian | Date |

**THIS AUTHORIZATION EXPIRES AFTER NINETY DAYS**