



The Steadman Clinic

181 West Meadow Drive STE 400
Vail Colorado 81657
T 970.476.1100 F 970.479.5835

AUTHORIZATION OF DISCLOSURE OF HEALTH INFORMATION

I hereby authorize The Steadman Clinic to release medical information from the records of:

Patient Name: _____ Date of Birth: _____ SS#: _____

Patient Street Address: _____

City: _____ State: _____ Zip Code: _____

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"/> Treatment Plan | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> Discharge Instructions | <input type="checkbox"/> Medication Records | <input type="checkbox"/> Clinic Note | <input type="checkbox"/> Pre-Operative Notes |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Lab Report | <input type="checkbox"/> Consultations | <input type="checkbox"/> EKG / ECG |

Other (specify): _____

Purpose / Need for the discloser: Insurance Legal Continued Medical Care Patient's Own Use
 Other:

The Information May Be Disclosed To The Following:

Recipients Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____ Fax #: _____

Delivery : I will pick-up my records Please mail records to the above address Other: _____

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

I acknowledge 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 actions taken in reliance on the authorization cannot be reversed and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____
Date

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

I understand 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 there may be costs associated with this request in compliance with State copying laws.

Signature of Patient or Personal Representative*

Date of Signature

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

- Parent Legal Guardian Healthcare Power of Attorney Administrator Executor of Estate Next of Kin Beneficiary