**Partners In Women's Health** Phone (303) 399-3315
Fax (303) 355-7088

AUTHORIZATION TO DISCLOSE HEALTH INFORMATON

**1.** I authorize the following practice/provider: _____
Phone: _____
Fax: _____

to release health information of the following individual named below:
Patient Name: _____
Phone: _____Date of Birth___/___/___ SSN: _____

**2.** I authorize the information to be disclosed to and used by the following individual or organization:

**Partners In Women's Health**
**DO NOT SEND ON A DISK**
4500 E 9th Ave., Ste700
Denver, CO 80220
Phone: (303) 399-3315 | Fax: (303) 355-7088

**3.** The type and amount of information to be disclosed is as follows:

_____

4. 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.

**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 based on it. 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 poly or the policy itself.

**6.** I understand that authorization for the disclosure of this health information is voluntary, and I can refuse to sign this authorization. PIWH cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on information carries with it the potential for an un-authorization re-disclosure and the information may not be protected by federal confidentiality rules.

_____
Signature of Patient or Authorized Personal Representative Date

_____
Personal Representative's Name (Print) and relationship Date
(Please attach applicable legal documentation or authority)