METRO MULTI-DISCIPLINARY DOCTORS
450 LINCOLN ST #104, DENVER CO 80203
720-519-1236 TEL / 720-708-3172 FAX

Patient Name: ____

Date of birth: ______________________ Social Security Number: ______________________

Address: ______________________ City: ______________ State: _______ Zip: ________

Home Phone: ______________________ Cell/Work Phone: ______________________

I authorize Metro Multi-Disciplinary Doctors to receive the information specified below from the organization, agency or individual named in this request. 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;
- that 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 and adult according to the state law;
- That I may revoke this authorization in writing at any time except to the extent that action has already been taken based on this authorization; that revocation will not apply to the 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;
- That authorization for the disclosure of health information is voluntary and that I can refuse to sign this authorization; that no one can condition treatment, payment, enrollment in a health plan or eligibility for benefits upon the signing of this authorization, except as otherwise permitted by law; that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the re-disclosure information may not be protected by federal confidentiality rules.

Purpose(s) or need for which information is to be used:

□ My personal records □ Attorney □ Insurance □ Continuity of Care

□ Disability claim □ Other (please explain): ______________________

Type of information to be disclosed is as follows (check the appropriate boxes and include other information where indicated):

□ Copy of Entire Record
□ Copy of history & physical, discharge summary and operative reports
□ Copy of Consultation Reports
□ Copy of Laboratory Reports / Radiology Reports
□ Alcohol/Drug Treatment
□ Mental Health Information
□ HIV related Information
□ Copy of complete Billing

□ Other (please explain): ____

Dates of Care Covered:

□ All □ Limited to treatment dates: ______________________

Name and address of health provider or entity **to release this information**:

Name: ____

Address: ______________________ City: ______________ State: _______ Zip: ________

Office Phone: ______________________ Office Fax: ______________________

Signature of patient or authorized representative: ______________________ Date: ______________

Printed Name: ______________________ Relationship to patient: ______________

Identification verified by: □ Driver License □ Other picture ID (Name): ______________ MMD Staff Initials: ________