COLORADO INTERNAL MEDICINE

A Concierge Medical Practice

Authorization to Disclose Protected Health Information to a Third Party

Patient's Full Name____
Date of Birth____
Address____

I, the undersigned, hereby authorize Colorado Internal Medicine and Dr. Diane Yang to disclose my Protected Health Information as specified below to the following person or organization:

Name ____
Address ____
Phone ______________________________________ Fax ______________________________

I am requesting that my Protected Health Information be released for the purpose of:

____
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Required Statements:
I understand that this authorization authorizes the release of all Protected Health Information including but not limited to information concerning psychiatric, drug or alcohol abuse, and communicable diseases such as HIV and/or AIDS.
I understand that the information provided based on this Authorization may be redisclosed to another party by the authorized recipient, and Colorado Internal Medicine and Dr. Diane Yang has no control over the additional disclosure and cannot protect the information after its release based on this authorization.
I understand that I may revoke this authorization at any time in writing to the address below. I understand that any revocation can apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions taken or disclosures made while the authorization was in effect.
Having read the above information, I hereby release and hold harmless Colorado Internal Medicine, its employees, staff and agents, in connection with the disclosure of information. I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed authorization is as effective as the original.

Patient's signature ______________________________________ Date ___________________________

Parent of legal guardian may sign on behalf of minor child.