COLORADO INTERNAL MEDICINE

A Concierge Medical Practice

Authorization For Release of Medical Records

Patient's Full Name____

Date of Birth____

Social Security Number___________________________

I, the undersigned, hereby authorize:

Physician/Clinic you are requesting records from:

Name____

Address____

____

Phone_________________________Fax __________________________

To release my medical records, laboratory, and diagnostic reports to:

Colorado Internal Medicine
Diane Yang, MD MPH
10535 Park Meadows Blvd, Suite 340
Lone Tree, CO 80124
Office: 720-428-2234
Fax: 833-438-4935

I am requesting that my **entire medical record** be released for the purpose of **continuing medical care**. I understand that this authorization authorizes the release of all medical records including but not limited to records concerning psychiatric, drug or alcohol abuse, and communicable diseases such as HIV/AIDs.

The information provided is confidential and any re-disclosure by the recipient is prohibited without written consent. **Records requested should be released within 30 days from receipt of this release.**

This consent to release confidential information may be revoked by me in writing, at any time, except to the extent that action has already been taken. No further confidential information will be released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby release, hold harmless and agree not to sue the practice, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

Patient's signature____________________________________Date__________

Parent/Legal guardian_________________________________Date__________