MILE HIGH REGENERATIVE AND PAIN THERAPY

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of Patient: _____ Date of Birth: _____

**I authorize _____ to disclose the protected health information described below to Mile High Regenerative and Pain Therapy, the office of Dr. Robert Brown.

**I authorize the release of protected health information covering the period of health care:

X from all past, present and future periods ***OR*** ☐ from _____ to _____

To Mile High Regenerative and Pain Therapy at _____
(Name of practice)
(fax #)

_____ (*Patient's Initials*) I request records to be faxed. I am aware of confidentiality risks involved and releases Mile High Regenerative and Pain Therapy from responsibility for this fax. I understand that the information in my medical record may include information relating to communicable diseases (including AIDS, HIV). It may also include information about behavioral and mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise below.

The following information is to be released:

- X Entire Record
- X Clinic Visit Notes
- X Radiology Reports
- X Lab Tests: _____
- ☐ Other: _____

RESTRICTIONS:

According to federal and state regulations, if the medical information required relates to AIDS/HIV treatment or treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law. I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient(s) may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I realized that the office and its employees have responsibility to maintain the confidentiality of the medical records in its possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. The recipient(s) will not be held responsible for any subsequent disclosure by the recipient of the health information.

MY RIGHTS:

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits. I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of. I may revoke this authorization at any time, but I must do so in writing and submit it to the follow address: *Mile High Regenerative and Pain Therapy, 12597 W. Bayaud Ave., Lakewood ,CO 80228*. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization. Information disclosed pursuant to this authorization could be re-disclosed by the recipient.

Patient Signature: _____ Date: _____