Denver East: 3894 Olive St. 80207 303.320.8352
Lafayette: 1285 Centaur Village Dr. 80026 303.665.2341
Englewood, Bella: 180 E Hampden #100 80113 **303.789.4968**

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient Information

Last Name, First Name	
Street Address	
City/State/Zip	
Daytime Phone Number	
Birthdate	

Release Medical Records FROM:

Marisol Health/Bella Natural Women's Care
180 E. Hampden Avenue Suite 100
Englewood, Colorado 80113
Phone: 303.789.4968 FAX: 303.789.6018

Release Medical Records TO:

Doctor/Hospital/Clinic	
Street Address	
City/State/Zip	
Phone Number	
Fax Number	

Information to be released:

☐ **2 years of medical records**

☐ **Just my health information relating to the following condition or treatment: _____**

☐ **Include records related to:**

☐ **psychological or psychiatric conditions;** ☐ **Alcohol and/or drug abuse;** ☐ **HIV/AIDS**

☐ **Other: _____**

Purpose of Disclosure:

☐ **Referral to a specialist** ☐ **Permanent Transfer** ☐ **Personal Insurance** ☐ **Workers Comp**

☐ **Legal Investigation** ☐ **Disability Determination** ☐ **Other**

*** This authorization is valid for 1 year from date of signature unless otherwise indicated.***

Patient Rights:

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. To revoke this authorization, either complete a Revocation of Authorization Form or provide written communication to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature: _____ Date: ___/___/____

Relationship to patient: _____
(or parent/legal guardian/legal representative) **updated 1.29.20**