AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

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

Patient Information

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

Release Medical Records FROM:

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

Information to be released:

Send Medical Records **TO:**
Marisol Health/Bella Health & Wellness
180E Hampden Ave, Suite 100
Englewood, CO 80113
Phone: 303.789.4968 FAX: 303.789.6018

☐ 2 years of medical records
☐ Just my health information relating to the following condition or treatment: ______________________________

☐ Include records related to:
☐ psychological/psychiatric conditions; ☐ alcohol/drug abuse; ☐ HIV/AIDS

☐ Other: ____

Purpose of Disclosure:

☐ Referral to a specialist
☐ Personal Insurance
☐ Legal Investigation
☐ Other

☐ Permanent Transfer
☐ Workers Comp
☐ Disability Determination

****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 to get health care (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 For 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:** ____/_____/_____
(or parent/legal guardian/legal representative)
Relationship to patient: ____