



HermitsPointMedicine.com

720-629-4211

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ request and authorize the release of medical records to the above named practitioner(s)

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization. It is valid until revoked in writing. Records are requested for continuity of care. *naha, llc* does not offer reimbursement for records received.

BIRTHDATE _____ SOCIAL SECURITY # _____

Please obtain information from the following Physician or Entity: _____

Contact Information for above Physician or Entity: _____

Please send my medical information to the following:

Hermits Point Medicine, LLC
6705 South Penrose Court
Centennial, Colorado 80122

jennifer@hermitspointmedicine.com

andrew@hermitspointmedicine.com

By checking the spaces below, I authorize the above practitioners to release written records pertaining to the following information going back _____ year(s). I also authorize Hermit's Point Medicine to provide the following information via telephone consultation.

Medical records needed for continuity of care

Pathology reports

Diagnostic imaging reports

Laboratory reports

Other _____

PATIENT SIGNATURE _____ **DATE** _____

I understand that certain information in these records cannot be released without specific authorization because of federal or state laws. By signing the spaces below, I specifically authorize the release of the following confidential information for us by Hermit's Point Medicine. I also authorize the Hermit's Point Medicine to provide the following information via telephone consultation.

MENTAL HEALTH DIAGNOSIS, TREATMENT AND REFERRAL INFORMATION, including high risk behavior documentation. This information may not be further disclosed without the specific written authorization of the diagnosed individual.

PATIENT SIGNATURE _____ **DATE** _____

HIV/AIDS TEST RESULTS, DIAGNOSIS, TREATMENT AND REFERRAL INFORMATION, including high risk behavior documentation. This information may not be further disclosed without the specific written authorization of the tested individual.

PATIENT SIGNATURE _____ **DATE** _____

DRUG/ALCOHOL DIAGNOSIS, TREATMENT AND REFERRAL INFORMATION. Federal Regulation 42 CFR Part 2 requires a description of how much and what kind of information is to be disclosed. Please provide a description of this information.

DESCRIPTION _____

PATIENT SIGNATURE _____ **DATE** _____

Office use only: Date sent: _____ : Sent by: _____ Initials: _____