AUTHORIZATION FOR THE DISCLOSURE OF MEDICAL INFORMATION

TO: ____

____
(name and address of health care provider)

RE: ____
(patient name)

DOB: ________________________ **SSN:** ________________________

I authorize the disclosure of all medical information (including X-rays, CT scans, MRIs, etc., and information related to treatment for alcohol or drug abuse, sickle cell anemia, HIV and mental health) maintained about me while I was a patient at your facility.

This information may be disclosed to **Acuity Services, 1764 Gilpin Street, Denver, CO 80218, its representatives, employees or designees.**

I understand that this authorization is voluntary. My health care and payment for my health care will not be affected if I do not sign this form. I understand, however, that my refusal to sign may adversely affect the investigation requiring these records.

I understand that I may revoke this authorization in writing. If I do, it will not affect any disclosures already made in reliance on this authorization.

I understand that, once this information has been disclosed, it may no longer be protected by privacy laws CFR 45 Privacy Rule Part 160 and 164 and could be re-disclosed.

This authorization expires 18 months from the date of signature.

A photocopy of this authorization will be treated in the same manner as an original.

____ ____________________
(Signature of Patient or Representative) (Date)

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(Relationship to Patient/Authority to Sign for Patient)