

Authorization to Disclose/ Transfer Health Information

I authorize Michael Douglas Mignoli, MD to release health information of the individual named below:

Patient Name (please print clearly): _____

Address: _____

Phone #: _____ Date of Birth: _____ SSN: _____

I authorize the information to be disclosed to and used by the following individual or organization:

Name of Physician, Clinic or Hospital: _____

Address: _____

The type and amount of information to be disclosed is as follows:

Immunizations Laboratory Results, from _____ to _____

Most recent 3 years of records X-ray reports, from _____ to _____

Entire Medical Record HIV/Aids information, from _____ to _____

Genetic testing Yes ___ NO ___

Other: _____

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history. I understand this authorization will expire, without my express revocation one year from the date of signing, or if I am a minor, on the date I become 18 years of age. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on this authorization. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorization for a discloser of this health information is voluntary and I can refuse to sign this authorization.

I accept full financial responsibility for copying fees. Per Colorado Department of Health and Public Environment Regulations, the fee for copying requested documents is \$14.00 for the first ten pages, \$.50 per page for pages 11-40, and \$.33 per page for each page over 40. There is no charge for records sent to another physician's office.

Signature of Patient or Authorized Personal Representative

Personal Representative's Name/Relationship

(Please attach applicable legal Documentation of Authority)

Date

Date