Doctors Care
609 W. Littleton Blvd., Ste. 100
Littleton, CO 80120
Phone 303-730-1313 Fax 720-458-6177

Release of Information Authorization

I ____ _______ / _______ / _______
First name Middle Initial Last Name Date of Birth

authorize Doctors Care to obtain information from and share information with: all participating Doctors Care providers.

Information may include (unless lined through):
- Assessment including diagnosis
- Treatment summary and recommendations
- Psychological testing/consultations
- Medical information/medications prescribed
- Drug/alcohol history and treatment
- Service plans
- Immunizations

Check to indicate the purpose for which information is to be released:

☒ Treatment operations or payment
(If checked, this form becomes a release and under Colorado law, service can be refused if patient refuses to sign)

☐ Other: [e.g. Law (attorney, probation), Education (schools) or Social Service]. If checked, this form becomes an Authorization and under HIPAA rules, service may not be conditioned or refused if consumer refuses to sign.
Specify: ____

I understand that, unless lined through, information to be released may include information regarding the following conditions:

Drug abuse	Psychiatric Conditions/Treatment
Alcoholism or alcohol abuse	HIV/AIDS

I understand that if this is a Release "Treatment, Operations and Payment" purpose Doctors Care may withhold treatment, payment, enrollment, or eligibility for benefits if I refuse to sign.

I understand that if this is an Authorization for "Other" purposes, Doctors Care may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign or not.

I understand that there is a potential for information disclosed as a result of this release/authorization to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulation.

I understand that I may revoke this release/authorization at any time by giving written notice to Doctors Care, except to the extent that action has already been taken to comply with. Without such revocation, this release/authorization will expire on ___ / ___ / ___ or if left blank, two years from the date of my signature or as of the action or event of: ____.

I understand I have a right to refuse to sign this form subject to the conditions noted above or if I sign I am entitled to a copy of the signed form.

____ ____
Signature of patient/patient legal representative Relationship to Patient

Witness: ____ Date: ____

Notice to whom this information is given: this information has been disclosed to you from records whose confidentiality is protected by federal law which prohibits you from making further disclosure of this information without the specific written consent of the person to whom it pertains.