Mile High Sports and Rehabiliation Medicine
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2490 W. 26th Ave. Suite 10A Denver, CO 80211
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Authorization for Disclosure of Medical Information

I hereby authorize (Name of Facility/Doctor): _____

Address: _____ to release and/or disclose the medical information as indicated below to:

- ☐ Mile High Sports and Rehabilitation Medicine 2490 W. 26th Ave., Suite 10-A Denver, CO 80211 or,

_____

Release and/or disclose records and information regarding:

_____ _____ _____
Name of Patient Date of Birth Phone Number

Covering the period of healthcare: From (date) _____ To (date) _____

Information to be disclosed:

- ☐ Complete health record(s)

Or, if partial record:

- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Laboratory/Pathology Reports
- ☐ Radiology (X-Ray, CT, MRI, US)
- ☐ Pharmacy/prescription records
- ☐ Other (please specify) _____

I understand that this will include information relating to (check if applicable):

- ☐ Treatment for alcohol and/or substance abuse
- ☐ Psychiatric Care
- ☐ Work Related Incidents
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV

I understand this authorization may be revoked in writing at any time, except with respect to action that has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

This facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Printed Name: _____ Date: _____

Signature of Patient or Responsible Party: _____