



Integrated Health Solutions

Authorization to Disclose Personal Health Information

Patient Name: _____ Date of Birth: ___/___/___ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

3. The type of information to be used or disclosed is as follows (include dates & specifications where appropriate):

- | | |
|--|--|
| <input type="checkbox"/> Problem List | <input type="checkbox"/> Physical Exams |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Consultation Reports from (please supply doctors' names): |
| <input type="checkbox"/> List of Allergies | <input type="checkbox"/> Entire Record |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Information related to treatment for any sexually transmitted disease, including HIV or AIDs* |
| <input type="checkbox"/> Most Recent History | <input type="checkbox"/> Information related to treatment for mental health-related illnesses* |
| <input type="checkbox"/> Lab Results: _____ | |
| <input type="checkbox"/> X-ray and/or MRI Reports: _____ | |
| <input type="checkbox"/> Other: _____ | |

*Must be checked for that specific information to be released.

4. This information may be disclosed to and used by the following individual or organization:

Name: Healing Horizons Phone: 970-256-8449 Fax: 970-241-2828

Address: 2139 N. 12th Street #7 City: Grand Junction State: CO Zip: 81501

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
6. This authorization will expire on (insert date or event): _____
If I fail to specify an expiration date or event, this authorization will expire six months from the date on which it was signed.
7. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
8. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

Patient/Guardian Signature: _____ Date: ___/___/___

Witness Signature: _____ Date: ___/___/___