

Release of Medical Information

Request Authorization of Protected Health Information (PHI) to CAAC

I authorize the use/disclosure of health information about _____
as described below: Patient name and date of birth

1. Persons(s) or class of persons authorized to use/disclose the information: name and address of disclosing party

Person(s) or class of persons authorized to receive the information:

- | | | |
|---|--|--|
| <input type="checkbox"/> Kara Crosby, MD | <input type="checkbox"/> Andrea L. Jones, MD | <input type="checkbox"/> David S. Pearlman, MD |
| <input type="checkbox"/> Mark A. Ebadi, MD | <input type="checkbox"/> Erin E. Kempe, DO | <input type="checkbox"/> Manujendra Ray, MD |
| <input type="checkbox"/> Shaila U. Gogate, MD | <input type="checkbox"/> Jerald W. Koepke, M.D | <input type="checkbox"/> Monica B. Reddy, MD |
| <input type="checkbox"/> Leon S. Greos, MD | <input type="checkbox"/> Nunthaporn Laoprasert, MD | <input type="checkbox"/> Katherine Tsai, MD |
| <input type="checkbox"/> John M. James, MD | <input type="checkbox"/> Grant C. Olson, MD | <input type="checkbox"/> Catherine M. VanKerckhove, MD |

- | | | |
|--|--------------|------------------|
| <input type="checkbox"/> 125 Rampart Way, Suite 100, Denver, CO 80230 | 720-858-7600 | Fax 720-858-7610 |
| <input type="checkbox"/> 2490 W. 26 th Ave., Suite A120, Denver, CO 80211 | 720-858-7474 | Fax 720-858-7488 |
| <input type="checkbox"/> 9331 S. Colorado Blvd., Suite 100, Highlands Ranch, CO 80126 | 303-795-8177 | Fax 303-797-2166 |
| <input type="checkbox"/> 1667 Cole Blvd., Bldg.19, Suite 200, Lakewood, CO 80401 | 303-420-3131 | Fax 303-420-1984 |
| <input type="checkbox"/> 3400 W 16 th St, Bldg 5, Unit Y, Greeley, CO 80634 | 970-356-3907 | Fax 970-221-0948 |
| <input type="checkbox"/> 13111 E Briarwood Ave, Suite 340, Centennial, CO 80112 | 303-632-3694 | Fax 303-632-3692 |
| <input type="checkbox"/> 6169 S. Balsam Way, Suite 360, Littleton, CO 80123 | 303-971-0311 | Fax 303-948-0339 |
| <input type="checkbox"/> 340 E. 1 st Ave., Suite 100, Broomfield, CO 80020 | 303-428-6089 | Fax 303-412-2141 |
| <input type="checkbox"/> 2014 Caribou Dr., Suite 200, Fort Collins, CO 80525 | 970-221-1681 | Fax 970-221-0948 |
| <input type="checkbox"/> 4700 E. Bromley Lane, Suite 207, Brighton, CO 80601 | 303-654-1234 | Fax 303-654-0955 |
| <input type="checkbox"/> 2352 Meadows Blvd., Suite 300, Castle Rock, CO 80109 | 720-858-7470 | Fax 303-797-2166 |
| <input type="checkbox"/> 7180 E. Orchard Road, Suite 107, Englewood, CO 80111 | 303-740-0998 | Fax 303-740-7250 |

2. Description of information that may be used/disclosed:

- | | |
|---|---|
| <input type="checkbox"/> Actual Skin Test Results (copy of testing sheet preferred) | <input type="checkbox"/> X-Ray Report |
| <input type="checkbox"/> Actual Recipe of Treatment Extract and Injection Record | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Evaluation and Treatment Summary | <input type="checkbox"/> Other (please specify) |

3. The information will be used/disclosed for the following purposes:

4. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

5. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

6. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. This authorization expires _____
(Date)

Signature of Patient or Representative

Date

Patient's Name (print)

Date of Birth