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:

☐ Allen D. Adinoff, MD	☐ Andrea L. Jones, MD	☐ David S. Pearlman, MD
☐ Mark A. Ebadi, MD	☐ Erin E. Kempe, DO	☐ Manujendra Ray, MD
☐ Shaila U. Gogoate, MD	☐ Jerald W. Koepke, M.D	☐ Monica B. Reddy, MD
☐ Leon S. Greos, MD	☐ Nunthaporn Laoprasert, MD	☐ Katherine Tsai, MD
☐ John M. James, MD	☐ Grant C. Olson, MD	☐ Catherine M. VanKerckhove, MD

☐ 125 Rampart Way, Suite 100, Denver, CO 80230	720-858-7600	Fax 720-858-7610
☐ 2490 W. 26th Ave., Suite A120, Denver, CO 80211	720-858-7474	Fax 720-858-7488
☐ 9331 S. Colorado Blvd., Suite 100, Highlands Ranch, CO 80126	303-795-8177	Fax 303-797-2166
☐ 1667 Cole Blvd., Bldg.19,Suite 200, Lakewood, CO 80401	303-420-3131	Fax 303-420-1984
☐ 3400 W 16th St, Bldg 5, Unit Y, Greeley CO 80634	970-356-3907	Fax 970-356-3825
☐ 14000 E. Arapahoe Road, Suite 240, Centennial, CO 80112	303-632-3694	Fax 303-632-3692
☐ 6169 S. Balsam Way, Suite 360, Littleton, CO 80123	303-971-0311	Fax 303-948-0339
☐ 340 E. 1st Ave., Suite 307, Broomfield, CO 80020	303-428-6089	Fax 303-412-2141
☐ 2014 Caribou Dr., Suite 200, Fort Collins, CO 80525	970-221-1681	Fax 970-221-0948
☐ 4700 E. Bromley Lane, Suite 207, Brighton, CO 80601	303-654-1234	Fax 303-654-0955
☐ 2352 Meadows Blvd., Suite 300, Castle Rock, CO 80109	720-858-7470	Fax 303-797-2166
☐ 7180 E. Orchard Road, Suite 208, Englewood, CO 80111	303-740-0998	Fax 303-740-7250

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

☐ Actual Skin Test Results (copy of testing sheet preferred)	☐ X-Ray Report
☐ Actual Recipe of Treatment Extract and Injection Record	☐ Consultation Reports
☐ Evaluation and Treatment Summary	☐ 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