# 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:

   ☐ Ryan Buckley, MD
   ☐ Kara Crosby, DO
   ☐ Mark A. Ebadi, MD
   ☐ Michael J. Flais, MD
   ☐ Shaila U. Gogate, MD
   ☐ Leon S. Greos, MD
   ☐ Erin E. Kempe, DO
   ☐ Jerald W. Koepke, MD
   ☐ Ross I. Palis, MD
   ☐ Monica B. Reddy, MD
   ☐ Katherine Tsai, MD

| Address | Phone | Fax |
|---|---|---|
| ☐ 125 Rampart Way, Suite 100, Denver, CO 80230 | 720-858-7600 | Fax 720-858-7610 |
| ☐ 3920 Federal Blvd, Unit B, 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 970-221-0948 |
| ☐ 13111 E Briarwood Ave, Suite 340, Centennial, CO 80112 | 303-632-3694 | Fax 303-632-3692 |
| ☐ 5920 South Estes Street, suite #120, Littleton, CO 80123 | 303-971-0311 | Fax 303-948-0339 |
| ☐ 340 E. 1st Ave., Suite 100, 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 107, 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)
   ☐ Actual Recipe of Treatment Extract and Injection Record
   ☐ Evaluation and Treatment Summary
   ☐ X-Ray Report
   ☐ Consultation Reports
   ☐ 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