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	☐ Erin E. Kempe, DO	☐ Monica B. Reddy, MD
☐ Mark A. Ebadi, MD	☐ Chad M. Lomas, MD	☐ Katherine Tsai, MD
☐ Michael J. Flais, MD	☐ Anna Meyer, MD	☐ Evelyn A. Wang, MD
☐ Shaila U. Gogate, MD	☐ Ross I. Palis, MD	

☐ 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
☐ 3980 Limelight Ave, Suite D, Castle Rock, CO 80109	720-858-7470	Fax 720-858-7444

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