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