brighton pediatrics

GET ON BOARD FOR WELLNESS

183 S. 18th Ave

Brighton, CO 80601

Phone: 303-659-4248

Fax: 303-659-4283

AUTHORIZATION TO RELEASE/RECEIVE PATIENT HEALTH INFORMATION

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Date of birth: __________________ Gender: _________

ddress:

____

ity/State/Zip________________________

A) I hereby authorize/request information FROM

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B) To be released TO:

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This disclosure can be used for the following purpose(s)

- Insurance
- Medical Treatment
- Medical Condition Verification
- Disability
- FMLA
- Workers Comp
- Personal
- Transferring Care
- Verbal communication between the two entities listed above
- Other: ________________________

Please indicate the type of information you authorize for release: Date Range: __________________to________________ ☐

****No more than THREE years unless requested by a physician or attorney****

- Only copies of Immunization Record, Growth Charts, last Physical or Well Baby exam.
- My health information relating to the following treatment or condition ________________________________
- All my health information maintained by the above practice. ***(Not including confidential information like behavioral health records and substance use records. To include please check those boxes as well.)***
- Behavioral Health Records
- Substance Use Records

My Rights I understand I do not have to sign this authorization to get health care benefits from Brighton Pediatrics for treatment, payment, or health care operations. However, a signature will be required if I am asked to take part in a research study, for marketing purposes or to receive health care when the purpose is to create health information for a third party. I understand that I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. I understand that I can revoke this authorization by writing a letter to this office. I understand that once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer

____________________________________ ________________________

Patient or legally authorized individual signature
Date

____________________________________ ________________________

Printed Name of patient or legally authorized individual **Relationship (self, parent, legal guardian etc.)**