Aileen Higgins, M.D.

3333 S. Bannock St. Suite 830

Englewood, CO 80110

720.295.1805 voicemail

844-750-0669 fax

 **AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Aileen Higgins, M.D. to release information

**To:** (*the entity to which Aileen Higgins, M.D. may provide protected health information, physician, hospital, etc.*):

**Name:** ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Phone: \_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Include:** (*Indicate by Initialing)*

\_\_\_\_\_\_\_\_ Mental Health Records including initial evaluation and progress notes

\_\_\_\_\_\_\_\_ Medication History

\_\_\_\_\_\_\_\_ Drug, Alcohol or Substance Abuse Records

\_\_\_\_\_\_\_\_ Lab results

**The purpose of this release of information is for (*initial all that apply*):**

\_\_\_\_ Coordination of Care (this allows for communication of protected health information between Aileen Higgins, M.D. and the person or entity who can receive and use this information)

\_\_\_\_ Release of written records

**I agree to the release of information for the following treatment (*please choose one and indicate by initialing*):**

\_\_\_ all treatment periods

\_\_\_ treatment dates from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form expires two years from date of signature **or** \_\_\_\_\_\_\_\_\_\_\_\_\_ (*specify date*)

I understand that I may revoke this release anytime by giving written notice, except to the extent that action has already been taken to comply with it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient Date