



Aspen Family Medicine – Green Valley Ranch  
 4809 Argonne Street, Ste. 150  
 Denver, CO 80249  
 303.563.2784 (ph)  
 303.563.2781 (fax)

**Authorization/Release For Use And Disclosure For Protected Health Information (PHI)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**For Disclosure Only: I hereby authorize the disclosure of the following Protected Health Information (PHI) of the patient listed above for the purpose of primary and/or follow-up care for a Workers Compensation Injury**

To  From

Aspen Family Medicine  
 Green Valley Ranch  
 4809 Argonne Street, Ste: 150  
 Denver, Co. 80249

To  / From  \_\_\_\_\_

PH: \_\_\_\_\_ Fax: \_\_\_\_\_

For Treatment Dates: \_\_\_\_\_

Type of Access Required: Copies of the Record  Inspection of the Record

**Selected Portions of Protected Health Information (PHI):**

- Entire Record       Lab       Progress Notes     Emergency Room     Imaging/Radiology     Physicians Orders
- History/Physical     Cardiac Studies     Billing Records     Consult Report     Demographics
- Internal Marketing     Operative Reports     Nursing Notes     Verbal Communications
- Rehabilitation/ PT     Medication Logs     Other: \_\_\_\_\_

Expiration: This Authorization Will Expire:  Fulfillment of this Request OR  Date: \_\_\_\_\_

1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing/results, or AIDS information. \_\_\_\_\_ (Initial)
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I will receive a copy of this form after I sign it.

I have read the above and authorize the disclosure of the Protected Health Information (PHI) as stated.

Signature of Patient/Guardian: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Date: \_\_\_\_\_