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Phone: (720) 222-0550
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Authorization for Release of Healthcare Information

Patient Name: ____ Date of Birth: _________________________

Maiden/Previous Name: ______________________________________ Phone Number: ________________________

Full Address: ____

I authorize Ballen Medical & Wellness to release and receive my healthcare information to and from the following healthcare provider(s)/person(s).

Number of Entities/Individuals specified below: ___________

1. Name: ____ Type of Provider: ______________________________
   Phone: _____________________________________ Fax: ____
   Address: ____

2. Name: ____ Type of Provider: ______________________________
   Phone: _____________________________________ Fax: ____
   Address: ____

3. Name: ____ Type of Provider: ______________________________
   Phone: _____________________________________ Fax: ____
   Address: ____

Information to be Released/Received:

☐ Service Dates: From: ______________ To: ______________ **OR** ☐ All future records until this authorization expires

☐ Entire Medical Record

☐ Abstract *(history & physical, discharge summary, operative reports, consults, outpatient visit notes, test results, labs, ER notes, provider notes related to specific timeframe)*.

☐ Discharge Summary ☐ ER Records ☐ History & Physical
☐ Clinic Visit Notes ☐ Psychological Evals/Assessments ☐ EKG/Cardiology Reports
☐ Immunization Records ☐ Lab/Pathology Reports ☐ Radiology Images
☐ Radiology Reports ☐ Billing Statements
☐ Alcohol/Drug Treatment Records: ____
☐ Other: ____

☐ **Do not release alcohol or drug treatment records protected under federal law**

I understand that this healthcare information may include mental health, alcohol, and/or drug treatment and will be used for the purposes of evaluation and treatment. I also understand that the authorization is completely voluntary and may be revoked at any time by submitting a written request to revoke the authorization to the office of Ballen Medical & Wellness (address listed above). I understand this authorization is voluntary and that I may refuse to sign. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment or my eligibility for benefits.

This authorization will expire on _______________ (or one year from date signed).

____ ______________________________
Patient Signature Date