

Jenny Demeaux RNC, ND  
Preventive Health Care for Women

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

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

SSN# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone # \_\_\_\_\_

<b>Information released __ to __ from: (please check)</b> <b>Name:</b> _____ <b>Address:</b> _____ _____ <b>Phone:</b> _____ <b>Fax:</b> _____	<b>Information released __ to __ from: (please check)</b>  <b>Jenny Demeaux RNC, ND</b> <b>3441 Tennyson Street</b> <b>Denver, CO 80212</b> <b>(303) 433-5006</b> <b>(303) 433-5016</b>
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Purpose for release of information (Please check one)

Attorney  Insurance  Doctor  Other \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

- The most recent 2 years of pertinent information (chart notes, labs, x-rays and Special tests)
- All medical records
- Specific information (Please specify) \_\_\_\_\_

**PATIENT AUTHORIZATION**

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

**EXCLUDE** the following information from the records released (please initial)

\_\_\_\_ Drug/alcohol abuse/treatment & diagnosis      \_\_\_\_ Sexually Transmitted Disease  
\_\_\_\_ HIV/AIDS diagnosis/treatment/testing      \_\_\_\_ Mental Illness or Psychiatric treatment

**MY RIGHTS**

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted in the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. I understand that this authorization will expire 1 year after the date on this form, unless otherwise stipulated. There is no charge for medical records if copies are sent to medical facilities for ongoing care or follow up treatment.

I hereby authorize the release of the medical records specified above.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of patient responsible party authorizing release information