



Pediatric Eyecare of Western Colorado, P.C.

Deborah S. Lenahan, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

_____ is authorized to use or disclose the following information
(Name of Agency)

from the health record of _____, _____,
(Patient Name) (Date of Birth)

Previous Name: _____, for

the period covering _____ to _____. The information is to be released to
(Beginning Date) (Ending Date)

(Name) (Address) (City, State & Zip)

for the purpose of continued patient care.

Information to be released includes (Check all that apply, cross out non-applicable items):

- | | |
|-------------------------------|---------------------------------|
| _____ Complete health records | _____ History and Physical Exam |
| _____ Procedure Report | _____ Laboratory Test Results |
| _____ Progress/Office Notes | _____ Other Test Results |

Other Reports: _____

I authorize the release of health records related to (Please circle all that apply):

YES / NO Acquired Immunodeficiency Syndrome (AIDS) and/or AIDS
Related Complex (ARC). HIV Status

YES / NO Alcohol/Substance Abuse Treatment Records

YES / NO Psychological or Psychiatric Conditions, including psychotherapy notes.

This authorization expires on _____.
(Expiration Date)

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

(Patient / Legal Representative)

(Date Signed)

(Printed Name if signed on behalf of the patient)

Relationship (parent, legal guardian, etc.)