

**HEALTHONE CLINIC SERVICES  
DENVER ENDOCRINOLOGY  
PHI RELEASE OF INFORMATION**

<b>Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient?</b> If yes, complete the Authorization for Research Form. If no, proceed to Section B.					
<b>Section B: Required for all Authorizations for Release of PHI or Right to Access</b>					
Patient Name:		Birth Date:		Social Security No. (optional):	
Patient's Address:		Requestor's Name/Phone Number (if patient is not the requestor):			
PHI Recipient Name: Leslie Gamache, M.D.	Address/City/State/Zip 1721 E 19 <sup>th</sup> Avenue, Suite 454, Denver CO 80218			Phone Number: (303) 228-1240 Fax Number: (303) 228-1250	
PHI Sender Name:	Address/City/State/Zip			Phone Number: ( ) _____ Fax Number: ( ) _____	
This authorization will expire on the following: (Fill in the Date or the Event, <u>but not both</u> .) Date: _____ Event: _____					
Purpose of Disclosure:					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on <u>this</u> authorization. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in record <input type="checkbox"/> History and Physical <input type="checkbox"/> Consult Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Progress Notes		<input type="checkbox"/> Physician Orders <input type="checkbox"/> Laboratory <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Record		<input type="checkbox"/> Demographics <input type="checkbox"/> Rehabilitation Services <input type="checkbox"/> Special Test/Therapy <input type="checkbox"/> Itemized Bill/Claims <input type="checkbox"/> Other:	
<ol style="list-style-type: none"> <li>1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)</li> <li>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).</li> <li>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.</li> <li>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 may be re-disclosed.</li> <li>5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.</li> </ol>					
I will receive a copy of this form after I sign it.					
<b>Section C: Signatures</b>					
<b>I have read the above and authorize the disclosure of the protected health information as stated.</b>					
Signature of Patient/Guardian/Patient Representative:				Date:	
Print Name of Patient's Representative:				Relationship to Patient:	