Pediatrics of Steamboat Springs

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Request for Medical Information

Patient Name: _____Date of Birth: _____

Please release my information by: ☐USPS Mail ☐Fax ☐Encrypted Email ☐Pick up in office

To: _____ **From**: _____
Mail to: _____ Address: _____
_____ _____
Ph# _____Fx#_____ Ph#:_____Fx#_____
Email: _____ Email: _____

The disclosure of information is for the purpose of:
____ Moving ____Changing Physicians ____ Insurance Application
____ Seeing Specialist (reason for appointment) _____
____ Other _____

Information to be disclosed:

❑ All of my health information that the provider has in his/her possession, **including information relating to drug or alcohol abuse, psychiatric history, HIV testing, sexually transmitted diseases, contraception and pregnancy.** (Cross out what you DO NOT want included.)

IF PATIENTS ARE 13YRS OR OLDER, THEY MUST SIGN FOR THE FOLLOWING:
I specifically consent to the release of information relating to:
Substance abuse (including drug/alcohol abuse)
Mental health (including psychotherapy notes)
Sexually transmitted diseases and HIV related information
Contraception and pregnancy counseling/evaluation
Signature: _____ **Name:**_____

❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)_____

This Authorization will expire 30 days from my signature below. I understand that I can revoke this authorization at any time by writing to my health care provider. I also understand that revoking this authorization will not affect disclosures made or actions taken prior to my provider receiving the written revocation.

Person Completing Release:_____ **Relation to Patient**:_____

Signature: _____ Date: _____