

Dr. Thomas Orvald MD.

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Authorization To Disclose Medical Records

This authorization must be written, dated and signed by the patient or by a person authorized by law to give authorization.

I authorize:

(Name of patients health care provider / Hospital)

to release a copy of the medical information for:

(Patient Name / Date of Birth & SSN# if applicable)

to: **Dr. Thomas Orvald MD.**

Fax:

(Phone / Fax #s)

Fax: **303-403-9998**

The information will be used on my behalf for the purpose of: **Continuity of patient care.**

Regarding the following condition(s):

By initialing next to the X's below. I specifically authorize the release of the following records:

X Medical Records -needed for continuity of care

X Last two Office Chart Notes -relating to condition

X HIV / AIDS – related records

X Genetic Testing Information*

X Mental Health Information*

X Diagnostic Imaging Reports*

* Must be initialed to be included in other records

X Drug / Alcohol Diagnosis, Treatment, or Referral Information

Permission to Fax Information:

X I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement, however. I understand that confidentiality on the receiving end cannot be guaranteed.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 90 days from the date of signing or shall remain in effect for a period reasonable to complete the request.

Date

(signature of patient)

Date

(signature of person authorized by law)

