Med Peds Clinic of Fort Collins, LLC
Mark S. Simmons, MD Christina M. Lang, MD Christopher R. Drysdale, MD
4674 Snow Mesa Drive, Ste 120
Fort Collins, CO 80528
Phone: (970)266-3650 Fax: (970)266-3660

Release of Information FROM Med Peds Clinic

Patient Name______________________________Date of Birth__________
Previous Name(s)______________________________

My Authorization

You may use or disclose the following protected health information: (check all that apply)

___ All information maintained by the below named practice
___EXCEPT: exclude info relating to: (circle all that apply)
Drug Abuse Alcohol Abuse HIV/AIDS Psychological or Psychiatric Conditions

___ Health information related to the following condition only______________________________

___ Health information for the following dates only______________________________

___ Other (please specify)______________________________

Information may be disclosed FROM Med Peds Clinic of Fort Collins, LLC

Information may be disclosed TO (check one)

___ Doctor/Clinic Name______________________________
Address______________________________
City/State/Zip______________________________
Phone #____________________Fax #____________________

___ Patient or Authorized Representative

Reason for authorization (circle all that apply)

Changing Doctors Consult with other Doctor Insurance Request Other

My Rights

I understand I do not have to sign this authorization to get health care benefits (treatment, payment or enrollment).
I understand that this release will be effective for 365 days (1 year) from the date it is signed, unless otherwise stipulated by myself.
I understand that I may revoke this release at any time by submitting a request in writing or filling out a revocation form at the clinic. If I choose to revoke this authorization, it will not affect any actions already taken by the Med Peds Clinic based upon the authorization.
I understand that I may not be able to revoke this authorization if it is for the purpose of obtaining insurance.

Signature______________________________Date__________

Relationship to Patient______________________________
Please note, you may not sign for another adult unless you are the Power of Attorney.