

**Med Peds Clinic of Fort Collins, LLC**

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**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                       Patient or Authorized Representative

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**Reason for authorization (circle all that apply)**

Leaving Clinic              Consult with other Doctor              Insurance Request              Other

**Reason for leaving:** \_\_\_\_\_

**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.