

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

**Information may be disclosed FROM**

Doctor/Clinic Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**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.