South Denver Internal Medicine
A Concierge Medical Practice at Sky Ridge Medical Center
Charles H. Miranda, MD, FACP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
(PLEASE PRINT OR TYPE)

Patient's Full Name: _____

Date of Birth: _____

Social Security Number: _____

I, the undersigned, hereby authorize:

Physician who you are requesting records from:

Physician Name: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____

to release my medical records, laboratory and diagnostic reports to:

South Denver Internal Medicine
Charles H. Miranda, MD
10103 Ridge Gate Parkway, Suite 114
Lone Tree, CO 80124
Office (303) 799-8890
Fax (303) 799-8891

I am requesting that my **entire medical record** be released for the purpose of **continuing medical treatment**. I understand that this authorization authorizes the release of all medical records including but not limited to records concerning Psychiatric, Drug or Alcohol Abuse, and communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS).

The information provided is confidential and any re-disclosure by the recipient is prohibited without written consent. **Records requested should be released within 30 days from receipt of this release.**

This consent to release confidential information may be revoked by me in writing, at any time, except to the extent that action has already been taken. No further confidential information will be released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS AND AGREE NOT TO SUE the Practice, its employees, staff and agents, in connection with the disclosure of information set forth relating to these medical records.

Patient's Signature _____ Date _____

Parent or Legal Guardian _____ Date _____