South Denver Internal Medicine

A Concierge Medical Practice

Charles H. Miranda, MD, FACP

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO A THIRD PARTY
(PLEASE PRINT OR TYPE)

Patient's Full Name: ____

Date of Birth: _____________________

Address, City, State, Zip Code:
____

I, the undersigned, hereby authorize South Denver Internal Medicine and Dr. Charles H. Miranda to disclose my **Protected Health Information** as specified below to the following person or organization:

Name: ____

Address: ____

Phone: _________________________ Fax: ________________________

I am requesting that my **Protected Health Information** be released for the purpose of:

____.

REQUIRED STATEMENTS:
I understand that this authorization authorizes the release of all **Protected Health Information** including but not limited to information concerning Psychiatric, Drug or Alcohol Abuse, and communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS).

I understand that the information provided based on this Authorization may be redisclosed to another party by the authorized recipient, and that South Denver Internal Medicine and Dr. Charles H. Miranda has no control over that additional disclosure and cannot protect the information after it is released based on this Authorization.

I understand that I may revoke this Authorization at any time in writing to the address below. I understand that any revocation can only apply to future disclosures or actions regarding the disclosure of my information and cannot cancel actions taken or disclosures made while the authorization was in effect.

Having read the above information, I hereby release and hold harmless South Denver Internal Medicine, its employees, staff and agents, in connection with the disclosure of information. I certify that this request has been made voluntarily and that the information given is accurate to the best of my knowledge. A copy of this executed Authorization is as effective as the original.

Patient's Signature: _____________________________ Date: ___________________

Parent or Legal Guardian may sign on behalf of minor child.
Legal Guardian, Power of Attorney, or equivalent may sign on behalf of adult-documentation is required.