Health ONE®

Cardiothoracic Surgery Associates

Physician Care℠

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:

Jason Sperling, MD
Cardiothoracic Surgery Associates
1444 S. Potomac Street #300
Aurora, CO 80012
Phone (303) 266-4650
Fax (303) 751-6069

The above information is released for continuity of health care.

I understand that this authorization is valid for 90 days after the date of my signature. I have the right to revoke this authorization at any time with the understanding that all or part of this information may have been used in good faith to the revocation.

I understand that this 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.

Patient's Signature: _____ Date: _____

Parent or Legal Guardian: _____ Date: _____