Injury Care Associates
www.injurycareco.com

Authorization for Disclosure of Medical Information

I hereby authorize (Name of Facility/Doctor): _____

to release and/or disclose the medical information as indicated below to:

- ☐ **Injury Care Associates Denver** 2490 W. 26th Avenue, Suite A-5, Denver, CO 80211
- ☐ **Injury Care Associates Thornton** 9351 Grant Street Suite 600, Thornton, CO 80229

or, _____

Release and/or disclose records and information regarding:

_____	_____	_____
Name of Patient	Date of Birth	Phone Number

Covering the period of healthcare: From (date) _____ To (date) _____

Information to be disclosed:

- ☐ Complete health record(s)

Or, if partial record:
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Laboratory/Pathology Reports
- ☐ Radiology (X-Ray, CT, MRI, US)
- ☐ Pharmacy/prescription records
- ☐ Other (please specify) _____

I understand that this will include *all of the below information* unless marked (CHECK TO EXCLUDE):
- ☐ Treatment for alcohol and/or substance abuse
- ☐ Psychiatric Care
- ☐ Work Related Incidents
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV

I understand this authorization may be revoked in writing at any time, except with respect to action that has already been taken in reliance on this authorization.

This facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Printed Name: _____ Date: _____

Signature of Patient or Responsible Party: _____