



### AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described below.

The following individual or organization is authorized to disclose the information:

- Reid Goodman, M.D.
- Wendy Berenbaum, M.D.
- Jennifer Linhorst, M.D.
- Kristine Eule, M.D.
- Jennifer Guggenheim, M.D.
- Erin Dressel, MD

MILE HIGH OB/GYN  
 425 S CHERRY ST, SUITE 300  
 DENVER, CO 80246  
 Phone (303)388-4631  
 Fax (303)388-2662

The following individual or organization is authorized to receive the information:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, ZipCode: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Phone: \_\_\_\_\_

What is the reason you are transferring care? \_\_\_\_\_

The information to be disclosed:

- Specific condition(s) \_\_\_\_\_
- Tests/Lab results only \_\_\_\_\_
- All medical records generated by this provider
- Specific dates of treatment \_\_\_\_\_
- Other \_\_\_\_\_

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and substance abuse.

Re disclosure: I understand that any disclosure of information carries with it the potential for re disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Expiration: This authorization will expire on \_\_\_\_\_ (date, event, or condition).

Signature of Patient or Representative

Date

Patient Name

Date of Birth

Maiden/Other Names Used

SS#

Name of Personal Representative (if applicable)

Relationship to Patient