

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH INFORMATION

I hereby authorize release of my confidential health information as described below. I understand this authorization is voluntary. I understand that if the organization(s) authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

Client name: _____

Date of Birth: _____

Person providing the information:

Person/organization receiving the information:

George Stahnke (719) 287-8023

4585 Hilton Parkway, Suite 202

Colorado Springs CO 80907

Description of information to be disclosed: _____

The release of information is being made:

- At the request of the individual
 If at the request of another, explain the purpose of the request: _____

* This authorization will expire on ____/____/____ (DD/MM/YYYY)

Carefully read the following statements before signing this authorization:

1. I may revoke this authorization at any time in writing, except as to information released before receipt of the revocation.
2. I understand that my health care will not be denied if I refuse to sign this authorization.
3. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections.
4. I am entitled to a copy of this authorization.

* Signature of Client

Date

Printed name of Client's representative: _____

* Signature of Client's representative

Date

Representative's authority to act on behalf of the Client. _____

*** Expiration date must be specified * Form must be completed before signing**

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION