AUTHORIZATION FOR RELEASE OF HIPAA-PROTECTED HEALTH INFORMATION

TAKE TWO HEALTH
2503 Walnut St #200
Boulder CO 80302
www.taketwohealth.com
tel: 303-557-2250
fax: 303-325-7688

TO:

_____
Health Care Provider

_____
Facility

_____
Facility Street Address

_____
City, State and ZIP

_____
Telephone

_____
Fax

_____
email

REGARDING:

_____
Patient Name

_____
Date of Birth

_____
Street Address

_____
City, State and ZIP

_____
Telephone

_____
Fax

_____
email

I authorize, request and direct the above-designated Health Care Provider to

☐ **RELEASE (send) and/or** ☐ **RECIEVE (get) my protected health information listed below to/from:**

Leto Quarles MD
TAKE TWO HEALTH
2503 Walnut Street #200
Boulder CO 80302
tel: 303-557-2250
fax: 303-325-7688

Information to be released shall include (check all that apply):

☐ **Transfer of Primary Care:** please send ONLY:
- ➢ Problem List
- ➢ Immunization Record
- ➢ Preventive Health Screenings
- ➢ Complete Medication List (past and present)
- ➢ Allergy List
- ➢ Past Medical & Surgical History List
- ➢ relevant health **summaries**

☐ Surgical or Operative Reports

☐ Pathology Specimen Reports

☐ Radiology (imaging) Reports

☐ Radiology Images (digital files preferred)

☐ Specialist Consultation Report(s)

☐ Correspondence (written to or on behalf of patient)

☐ Nursing Notes

☐ Therapy Notes

☐ Billing Records

☐ Other: _____

This form is for the release (sharing) of **DOCUMENTS** in the health record.

TAKE TWO HEALTH also has a separate form to authorize **CONVERSATIONS** with other healthcare practitioners, advocates, caregivers, friends, family or others, which does not require that documents from the health record be shared.

Please be aware that **TAKE TWO HEALTH** has an open medical record. By design, any and all health records shared with **TAKE TWO HEALTH** will be visible to, and downloadable by, the patient and/or their legal guardian.

I ☐ **DO** / ☐ **DO NOT** consent for information regarding **MENTAL HEALTH** to be released.

I ☐ **DO** / ☐ **DO NOT** consent for information regarding **USE OF ALCOHOL, DRUGS, AND ILLICIT OR CONTROLLED SUBSTANCES** to be released.

I ☐ **DO** / ☐ **DO NOT** consent for information regarding **HIV STATUS OR HIV TESTING** to be released.

I am requesting that this information be shared for the following reason:

- ☐ Continuing care
- ☐ Specialty Consultation or Second Opinion
- ☐ Maintain personal records
- ☐ Legal Purposes
- ☐ Reimbursement
- ☐ Other (please specify): _____

Consent for release of information shall expire:

- ☐ immediately after records have been released once
- ☐ in one year

You may revoke your consent in writing at any time. If you do not otherwise specify, your consent will be valid for one calendar year from the date of your signature.

_____

Signature of patient or legal representative

_____

Printed Name of patient or legal representative

_____

Relationship to patient

_____

Date