PARAMOUNT HEALTH DIRECTIONS
52 Monroe St.
Denver, CO 80206
(P) 303-393-1726 (F) 303-200-9009

AUTHORIZATION FOR DISCLOSURE OF PROTECTED MEDICAL INFORMATION

Patient Name _____ Date of Birth _____

I, _____, (Responsible Party) hereby authorize the mutual exchange of information between Paramount Health Directions, and

_____
Name of hospital, physician, clinic, school, teacher, etc.

_____
Address of hospital, physician, clinic, school, teacher, etc.

_____
City, State, Zip Code

_____ _____
Telephone number Fax number

Medical Information authorized for disclosure:

_____ Admission note (history and physical)
_____ Discharge note
_____ Laboratory reports
_____ Complete psychological hospital report
_____ Outpatient records
_____ Emergency room records
_____ Case discussion
_____ Psychiatric evaluation, and treatment

I hereby authorize the Organization/Individual listed above to provide the requested information and release them from all liability and any and all claims of any nature whatsoever pertaining to this disclosure of information regarding medical treatment of the patient named above. A photocopy or email attachment of this request will be considered as valid as the original. This authorization is voluntary and evaluation and/or treatment are not conditional upon its being signed.

This authorization for disclosure of information may be revoked in writing by the patient or responsible party at any time but cannot apply to any action that has already been taken based on this release and cannot apply to information that has already been disclosed. Disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not then be protected by federal confidentiality rules.

Signature of Responsible Party: _____

Date: _____