VEROS HEALTH
Excellence in Complex Care

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IMMUNOE HEALTH CENTERS
ALLERGY, ASTHMA & IMMUNOLOGY
CHERRY CREEK FACE & SKIN
SINUS SOLUTIONS
SLEEP SOLUTIONS

AUTHORIZATION TO RELEASE/OBTAIN MEDICAL INFORMATION

Patient full name: _____

Date of birth: _____

VEROS HEALTH is authorized to

- ☐ Release Information to:
- ☐ Obtain Information from:

Clinic Name:

_____

Clinic Address:

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

NOTICE: Without a name, phone and fax number, your request for medical records may be delayed or unable to be completed.

Please provide us with appropriate contact information to obtain records. This request is valid for one year from the date of request unless otherwise specified.

I specifically authorize disclosure of the following information (check all that apply):

- ☐ All Medical Records
- ☐ Behavioral/Mental Health/Psychiatric Records
- ☐ Genetic Counseling/Testing
- ☐ Assessment/Evaluation Report
- ☐ Alcohol/Drug Abuse/Treatment
- ☐ Lab Results
- ☐ HIV/AIDS
- ☐ Education Records
- ☐ Sexually Transmitted Infections
- ☐ Other: _____

I understand I do not have to sign this authorization to obtain health care benefits (treatments, payments, enrollment or eligibility). I understand that I have a right to revoke this authorization at any time. Once the office discloses information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it. If I revoke this authorization, it will not affect any actions already taken. I have been offered a copy of this form.

_____ _____

Signature of patient/legally authorized individual Date

_____ _____

Printed Name if signed on behalf of the patient Relationship