AUTHORIZATION AND CONSENT FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION:

Name (last, first, MI) ______________________ Aspen Medical Record # ______________________

Street Address ______________________ Social Sec. No. ______________________ Birthdate

City/State/Zip ______________________ Telephone Number ______________________

INFORMATION RELEASED FROM:

Name (Clinic, Physician, Hospital or other sources) ______________________

Street Address ______________________

City/State/Zip ______________________

INFORMATION RELEASED TO/EXCHANGED WITH

Name (Clinic, Physician, Hospital or other sources) ______________________

Street Address ______________________

City/State/Zip ______________________

TYPE OR EXTENT OF INFORMATION TO BE DISCLOSED (check applicable category):

____ Records pertaining to: ______________________
(State specific conditions, inclusive of dates of treatment)

____ *Current Aspen Record (excludes transferred records)
____ Lab reports
____ Xray reports
____ Other (specify) ______________________

All records relating to alcohol and/or drug treatment, mental health records and communicable diseases will be released unless otherwise indicated here in writing:

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*It is Aspen's policy to release only the last three current years of medical information from patient records, unless otherwise specified This does not include records transferred to Aspen from other Health Care facilities.

INFORMATION IS TO BE RELEASED/EXCHANGED FOR THE FOLLOWING PURPOSE:

____ Personal
____ Continuing Care/Consultation
____ Insurance application or claim report
____ Insurance Change
____ Legal
____ Other (explain) ______________________

I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR 12 MONTHS UNLESS CANCELLED BY ME IN WRITING AND THAT MY CANCELLATION WILL TAKE EFFECT WHEN THE PROVIDER RECEIVES MY WRITTEN NOTICE. A PHOTOCOPY OF THIS CONSENT WILL BE TREATED IN THE SAME MANNER AS THE ORIGINAL.

Patient/Guardian Signature ______________________ Date ____________

If other than patient, state legal relationship ______________________

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