AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

FULL NAME________________________________ BIRTHDATE __________

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I hereby authorize DANA L. COGAN, M.D., at 600 South Cherry Street, Suite 315, Denver, CO 80246 to:

( ) RELEASE confidential information

( ) RECEIVE confidential information

TO/FROM: ____

ADDRESS:

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TELEPHONE NUMBER: _______________ FAX NUMBER: _______________

INFORMATION TO BE RELEASED:	**INFORMATION TO BE RECEIVED:**
( ) Treatment summary	( ) Copies of pleadings
( ) Alcohol/drug history	( ) Copies of medical/mental health records
( ) Evaluation report(s)	
( ) Consultation report(s)	( ) Substance abuse records
( ) Progress report(s)	( ) Probation/parole reports
( ) Copy of complete record	( ) Police records
( ) Other__________________	( ) Other________________________

PURPOSE OF RELEASE:

( ) To exchange verbal and written information with my attorney

( ) Other____

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RELEASE FROM LIABILITY:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, and drug and/or alcohol abuse.

EXCLUDE the following information from the records released (please initial):

______ Drug/alcohol abuse/treatment and diagnosis

______ HIV/AIDS and/or STD diagnosis/treatment/testing

I understand that I do not have to sign this authorization to obtain health care benefits (treatment, payment or enrollment).

I understand that I am free to revoke this release authorization at any time by notifying Dr. Cogan in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

I understand that Dr. Cogan will act on this release once it is signed. I understand that any release of information prior to my revoking the release shall not constitute a breach of my right to confidentiality.

I understand that Dr. Cogan must provide information to the police and/or the Department of Human Services if he suspects child abuse or believes that a person is dangerous to himself and/or others. I understand that Dr. Cogan may be required by law to release information even after I have revoked this release authorization. In such an instance, I agree to hold Dr. Cogan harmless regarding the release of my protected health information.

AUTOMATIC EXPIRATION:

( ) One (1) year from date signed ( ) Other: ______________

______________________________________ ____________

SIGNATURE DATE