Sleeping Bear Pediatrics
Mailing: P.O. Box 882470 ◦ **Physical Address** 405 Anglers Drive ◦ Steamboat Springs, Colorado 80488 **email** : sbpssco@gmail.com
Phone: 970-879-2327 Fax: 970-879-1972

Authorization to Disclose Health Information

Patient Name: _____
Address: _____
Phone: _____ DOB: _____

I authorize the information to be release from:
Name: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: _____ Fax: _____
I authorize the information to be disclosed to:
Name: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: _____ Fax: _____

Medical Records to be released:
○Medical Records ○ Most recent 2 years ○ Immunizations only ○ Lab Result Date: _____
○Other:_____

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
I understand this authorization will expire, without express revocation, one year from the date of signing, or if I am a minor, on the date that I become adult according to state law. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization of tom my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. Sleeping Bear Pediatrics cannot condition treatment, payment, enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I accept full financial responsibility for copying fees. Per Colorado Department of Public Health and Environment Regulations. The fee for copying requested documents is $18.50 for the first ten pages, $0.85 per page for pages 11 through 40 and $0.57 per page for each page over 40. Shipping and applicable sales tax will also be charged. Additional copies of records will be charged.

Signature Of Parent/Authorized Guardian _____
PRINT NAME _____ Relationship _____ Date_____