

The Office Of  
Eric A. Eisenbud, MD  
2420 W. 26<sup>th</sup> Ave. #480-D  
Denver, CO 80211  
**Phone:** (303) 403-9996 **Fax:** (303) 403-9998

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**AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

This authorization must be written, dated and signed by the patient, or by a person authorized by law to give authorization.

**Phone:** \_\_\_\_\_

I authorize: \_\_\_\_\_ **Fax:** \_\_\_\_\_  
(Clinic and doctor name)

to release medical information for:

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient Telephone Number:** (\_\_\_\_\_) \_\_\_\_\_  
Area Code

to the office of Eric Eisenbud, MD. Information will be used for continuity of patient care relating to the following medical condition(s): \_\_\_\_\_

By **INITIALING NEXT TO THE 'X'S BELOW**, I specifically authorize the release of the following:

**Initial Here**

\_\_\_\_\_  Clinician office chart notes (**regarding condition above**)

\_\_\_\_\_  Diagnostic imaging reports (**regarding condition above**)

\_\_\_\_\_  \*HIV/AIDS-related records

\_\_\_\_\_  \*Mental Health Records

\_\_\_\_\_  \*Drug and alcohol-related records

\*Must be initialed to be included with other documentation

**INITIAL  
HERE**

<p><b>PLEASE SEND THIS FORM WITH MEDICAL RECORDS</b></p>
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**PERMISSION TO FAX INFORMATION:**  YES \_\_\_\_\_

I specifically consent to the faxing of my medical records. All faxed material will contain a confidentiality statement; however, I understand confidentiality at the receiving end cannot be guaranteed. This authorization may be revoked at any time. The only exception is when action has been taken in reliance of the authorization. Unless revoked earlier, this consent will expire 90 days from the date of signing or shall remain in effect for the period reasonable to complete the request. I understand that your office will not condition treatment on signing the document, or failure to do so. I further understand that information disclosed by this authorization will not be subject to re-disclosure without my explicit written permission.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_