

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**CARDIOLOGISTS**

- Gary J. Luckasen, M.D., FACC
- Dennis G. Larson, M.D., FACC
- William E. Miller, M.D., FACC
- Todd B. Whitsitt, M.D., FACC
- Thomas R. Downes, M.D., FACC
- Roger C. Ashmore, M.D., FACC
- Stephen A. Treat, M.D., FACC
- C. Patrick Green, M.D., FACC
- C. Timothy Johnson, M.D., FACC
- Wyatt F. Voyles, M.D., FACC
- Anthony H. Doing, M.D., FACC
- Gerald I. Myers, M.D., FACC
- J. Bradley Oldemeyer, M.D., FACC
- Chad L. Stoltz, M.D., FACC
- Matthew Purvis, M.D., FACC
- William B. Baker, M.D., FACC
- Charles W. Tate III, M.D.
- Justin A. Strote, M.D.

**SURGEONS**

- Mark Guadagnoli, M.D., FACC, FACS
- Fernando LaMounier, M.D., FACC, FACS
- ABIM Board Certified  
Cardiovascular Diseases

Patients Legal Name: \_\_\_\_\_

Medical Record # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Heart Center of the Rockies  
2121 E. Harmony, Suites 100 & 200  
Fort Collins, CO 80528  
(970) 221-1000  
Fax: (970) 297-6886 or (970) 221-1544

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- Cath Lab Reports     CV Lab Reports     Recent History & Physical
- Recent Discharge Summary     X-ray and Imaging Reports     Office Notes
- Laboratory Results / Time Period \_\_\_\_\_
- Entire Record     Other \_\_\_\_\_

4. This information may be disclosed to and used by the following individual or organization:

Name, First and Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

For the purpose of \_\_\_\_\_

5. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

6. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 165.524. I understand information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy of the information, and such information is no longer protected by federal health information privacy regulations. If I have questions about disclosure of my health information, I can contact the Privacy Officer.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Signed by Legal Representative, Relationship to Patient

\_\_\_\_\_  
Date