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MEDICAL RECORDS RELEASE

I, _____, (DOB) _____

hereby authorize Deborah Meyers, CNP, MS; Maureen Goldman CNP, BCB-PMD; Sage Health Care, LLC, 72 Suttle St., Ste C, Durango, CO 81303

TO: RELEASE / RECEIVE (circle) the medical information from medical records listed below
TO / FROM (circle) :

Practice Name and Address (as needed): _____

Practice Phone _____ Practice Fax Number _____

Medical Records to be released: (check all that apply)

_____All Records

_____ Last 2 years of annual exam report

_____ Progress / Office Notes

_____ Lab Reports

_____ Diagnostic Imaging Reports (please specify) _____

_____ Other (please specify) _____

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. My information disclosed per this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy Rule. I may revoke this consent in writing at any time.

_____ _____
Signature of Patient or Guardian **Date**

_____ _____
Signature of Witness **Date**