Monument Women's Healthcare
610 25 RD | Grand Junction, CO
(PHONE) 970-986-8900 | (FAX) 970-986-8903

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____
Zipcode: _____ Phone: _____ Email: _____

RELEASE FROM

Organization: _____
Address: _____
City:_____
State: _____ Zipcode: _____
Phone: _____
Fax: _____

RELEASE TO

Organization: _____
Address: _____
City:_____
State: _____ Zipcode: _____
Phone: _____
Fax: _____

The following information to be released may include (Ch eck all that apply):

☐ A. All Health information pertaining to medical history, mental or physical condition, and treatment received.

OR

☐ Only the following records or types of health information (including any dates): _____

B. **Initial as necessary**, The following information may be authorized for release:

_____ HIV / Hepatitis / Sexually Transmitted Diseases Test Results
_____ Drugs and/or Alcohol Treatment

Purpose of requested use or disclosure:_____
_____

This authorization expires a year from today, _____.

_____ _____
Patient or Authorized Representative Signature Printed Name — Relationship to Patient