Peak Anesthesia & Pain Management/Advanced Pain & Anesthesia Svcs
Authorization to Release Health Information

Patient Name (list previous name if changed) _____ Date of Birth _____

Telephone _____ Social Security _____

Send Records to: Peak Anesthesia & Pain Management or Advanced Pain & Anesthesia
145 Inverness Drive East, Suite 350, Englewood, CO 80112

Other Provider:

Provider/Practice Name _____ Phone _____

Address _____ Fax _____

City, State, Zip Code _____

I [ ] do [ ] do not (check applicable box) authorize this information to be faxed.
If yes, fax number: 720-870-7460

This information is being disclosed for the purpose of Continuing Health Care.

For Healthcare Covering the Period(s) [ ] All or From: _____ To: _____

[ ] Complete Health Record to be disclosed or (check appropriate boxes):
[ ] History & Physical Exam [ ] Progress Notes [ ] Discharge Summary
[ ] X-Rays / Ultrasounds [ ] Laboratory Tests [ ] Consultations

I understand that specific information to be released may include AIDS or HIV, Alcohol and/or Drug Abuse, and Mental Health.

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein. I understand that The Medical Records Department at Peak Anesthesia and Pain Management has 30 days to respond to this request.
Unless otherwise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may a fee for preparing and furnishing thus information.

Signature of Patient or Legal Representative _____ Relationship to Patient _____ Date _____