Daniel B. Jinich, M.D., P.C.

Today's Date: ___________________________

Patient's Name: ____Date of Birth: ___________________
Address: ____
City/State/Zip Code: ____

I authorize: ____
____
____
____

To disclose/release the following information to:

Daniel B Jinich, M.D.
2001 S. Shields Bldg E Suite 201
Fort Collins, CO 80526
Phone: 970-221-9991
Fax: 970-221-9992

Type of Records Requested: Dates From: ________________ Through: _______________

_____ Immunization history

_____ My complete medical records

_____ My health information relation to the following treatment or condition_________________________.

_____ Other

Please circle to indicate **INCLUDE or EXCLUDE** on information below:

Include or Exclude: Drug Abuse related health information
Include or Exclude: Alcohol Abuse health information
Include or Exclude: HIV/AIDS health information
Include or Exclude: Psychological or psychiatric conditions, including psychotherapy notes.

This authorization will expire one year from the date of this authorization **OR**________________________. This authorization applies to the records prior to the date of this authorization. I may cancel this authorization at any time by submitting a **written** request to the office of Daniel B. Jinich, M.D., P.C., except where a disclosure has already been made in reliance on my prior authorization. I understand that after the custodian of records discloses health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization which will not affect my ability to obtain treatment or payment or eligibility for benefits. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

____
Signature of Patient or Representative Date

____
Print Name Relationship