# Highlands Health For Life
## Whitney Kennedy M.D.

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, _____ (patient or legal guardian of patient) do hereby request the release of my medical records as specified below:

**From:**

_____

_____

_____

_____

**To:**

Highlands Health For Life
4104 Tejon St.
Denver, CO 80211
P- (303) 381-3700
F- (303) 477-4118

_____ Summary of patient record including immunization records
_____ All records pertaining to _____
_____ Entire patient record

RESTRICTIONS: Items not to be released: _____
Reason for release of information:

_____ Change of insurance
_____ Change of Physician
_____ Other: _____

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse and past medical history.
I understand this authorization will expire, without my express revocation, either one year from the date of signing, or if I am a minor, on the date I become an adult according to state law, whichever occurs first. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken based on it. I understand that revocation will not apply to information that has already been released as specified by this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy or the policy itself.
I understand that authorization for the disclosure of this health information is voluntary and I can refuse to sign this authorization. The provider cannot condition treatment, payment, and enrollment in the health plan or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**Patient Name: _____ Date of Birth:_____**

**Signature: _____ Date: _____**

**Witness: _____ Date: _____**