Mile High Sports and Rehabiliation Medicine
Samuel Y. Chan, M.D.   Yusuke Wakeshima, M.D.
2490 W. 26th Ave. Suite 10A Denver, CO 80211
Ph: 303-331-6744   Fax: 303-331-6839

Authorization for Disclosure of Medical Information

I hereby authorize (Name of Facility/Doctor): ______________________________

Address: ______________________________ to release and/or disclose the medical information as indicated below to:

- ☐ Mile High Sports and Rehabilitation Medicine 2490 W. 26th Ave., Suite 10-A Denver, CO 80211   or,

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Release and/or disclose records and information regarding:

______________________	______________	______________
Name of Patient	Date of Birth	Phone Number

Covering the period of healthcare: From (date) ______________ To (date) ______________

Information to be disclosed:
- ☐ Complete health record(s)

Or, if partial record:
- ☐ Progress Notes
- ☐ Consultation Reports
- ☐ Laboratory/Pathology Reports
- ☐ Radiology (X-Ray, CT, MRI, US)
- ☐ Pharmacy/prescription records
- ☐ Other (please specify) ______________________________

I understand that this will include information relating to (check if applicable):
- ☐ Treatment for alcohol and/or substance abuse
- ☐ Psychiatric Care
- ☐ Work Related Incidents
- ☐ Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV

I understand this authorization may be revoked in writing at any time, except with respect to action that has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________

This facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient Printed Name: ______________________________ Date: ______________

Signature of Patient or Responsible Party: ______________________________