Brian T Stutz, DC, PC
400 S Colorado Blvd, suite 850
Denver, CO 80246
303-733-2521
drbrianstutz.com

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize the office of Brian T. Stutz, D.C., P.C. to disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:_____
Address:_____

Purpose: I authorize the release of my health information for the following specific purpose:

_____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ❑ Only the following records or types of health information:
  _____.

Term: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:_____

_____ _____ _____
Signature ***Date*** ***Signature of Witness***

_____