FOUR CORNERS CHILDREN'S CLINIC
Jessica Rensner, CPNP

4CCC Release of Information:

Authorization to release protected health information

Patient Information:		
Full Name:	Date of Birth:	Phone Number:
Responsible Party's Printed Name:	Relationship to the Patient:	

I hereby authorize disclosure/release of the Protected Health Information specified in this request to the organization, agency, or individual named below:

Release (Circle One): To/From	Release (Circle One): To/From
4 Corners Children's Clinic	Agency/Individual's Name:
555 Rivergate Lane B1-109 Durango, Colorado 81301 P (970) 422-8694/ F (970) 422-8696	Address/Phone/Fax:
Purpose of Disclosure (please circle one): Transfer of care Continuity of Care Personal Legal Insurance Other (Please Specify):	
Records to be Released (please circle one): Full Record Dates of Services: to Other (please specify):	

Please Note: The information to be released may include a diagnosis or reference to the following condition(s): behavioral health services/psychiatric care, sickle cell anemia, genetic testing, acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); drug and/or alcohol abuse, or sexually transmitted diseases.

To EXCLUDE any of this information, please initial next to each as necessary:

Drug/alcohol abuse/treatment & diagnosis

Reproductive health care/Sexually transmitted disease

Mental health/Psychiatric treatment

HIV/AIDS diagnosis/treatment/testing

*Patient signature required below to release these specific records:

- Patient age 13 or older: Reproductive health including pregnancy and sexually transmitted disease, HIV/AIDS, or drug/alcohol treatment information.
- Patient age 15 or older: Behavioral health or psychiatric care information.

I understand the following: This authorization will automatically expire one year from the date signed below or the date the minor child becomes an adult under state law, unless I request an expiration date sooner than 1 year. I may choose to revoke this authorization at any time, except to the extent that action has already been taken to comply with it, by notifying 4 Corners Children's Clinic in writing. Information disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by the HIPAA Privacy Rule. I have a right to a copy of this authorization. 4CCC will still provide treatment and seek payment for services provided, whether I sign this authorization. 4CCC may charge for copies of medical records.

Patient Signature:	Date:
Guardian Signature:	Date: