CASTLE ROCK
MEDICAL CENTER

Authorization for Release of Information

To authorize the release of medical or billing information to family members or others, please complete this form indicating who you would like your information shared with and what information you would like to disclose.

Patient Name:____ Date of Birth:_________________

Information I authorize to be disclosed:

- ☐ Appointment Date/Times
- ☐ Medical records
- ☐ Billing Information
- ☐ Mental Health
- ☐ HIV and Aids Information
- ☐ Alcohol/Drug Information

I hereby authorize Castle Rock Hospital District to disclose my personal health information that is checked above to the following individuals:

1.____Relationship:______________

2.____Relationship:______________

3.____Relationship:______________

4.____Relationship:______________

I understand that:

This Release of Information will remain in effect until terminated by me in writing.

I may revoke this authorization at any time in writing.

This authorization is giving Castle Rock Hospital District the right to discuss my medical and billing information with the individuals listed above.

Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA.

Signature:____Date:___________________

Witness Signature:____Date:___________________

Witness printed name:______________________________________