JOEY ADAM LERNER, M.D., M.P.H.
WADE T. MARKLAND, M.D.
WENDY BIGELSON, M.S.W., L.C.S.W.
5277 MANHATTAN CIRCLE, SUITE 110
BOULDER, COLORADO 80303
303-543-5785 phone
303-543-5782 fax

AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

DATE: _____

PATIENT NAME _____

DATE OF BIRTH _____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

I request and authorize Joey Lerner, MD, Wade Markland MD and/or Wendy Bigelson, LCSW. to ❒ release, ❒ receive, and/or ❒ exchange Protected Health Information regarding the patient listed above to or from:

To/From: NAME_____
ADDRESS_____
CITY_____ STATE _____ZIP CODE_____
PHONE_____ FAX_____

Purpose of request:
- ❒ Copy and send all records and labs
- ❒ Communication between providers of care
- ❒ Continuity of care
- ❒ Legal
- ❒ Other (specify)

Specific information to be excluded from this authorization:_____

According to Colorado State Statutes (6 CCR 1101-1, Ch. 1, Part 5), there is a charge for copies of medical records. The charge is $18.53 for the first 10 pages, $0.85 per page for pages 11-40, and $0.57 per page for pages 41 and above.

PATIENT SIGNATURE_____DATE_____

LEGAL GUARDIAN SIGNATURE (If different from patient) _____

WITNESS SIGNATURE _____

This consent will automatically expire one year after the date on which it was signed.

Photocopies of this consent form are acceptable.