RYON MEDICAL & ASSOCIATES, LLC.

P.O. Box 497
318 Lacey Avenue
La Junta, Colorado 81050
719-384-0303 (Phone) ~ 719-384-1033 (Fax)

PATIENT:

_____ _____
Name of Patient/Previous Names | Birth Date/Medical Record Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES:

_____
_____
_____

TO RELEASE /RECEIVE HEALTH INFORMATION TO/FROM:
Ryon Medical & Associates, LLC.
318 Lacey Avenue
La Junta, CO 81050

INFORMATION TO BE RELEASED: **____ Entire Medical Record (Include all)**

____ Medical History, Examination, Reports ____Surgical Reports ____ Immunizations
____ Treatment or Tests ____ Hospital Records Including Reports
____ X-ray Reports ____ Allergy Records ____ Laboratory Reports
____ Prescriptions ____ Consultations
____ Other (Specify): _____

In compliance with Colorado Statutes, which require permissions to release otherwise privileged information, please release records pertaining to: **____ Entire Medical Record (Include all)**

____ Mental Health ____ Developmental Disabilities ____ Alcoholism
____ HIV/AIDS ____ Sexually Transmitted Disease ____ Drug Abuse
____ Other (Specify): _____
For the following date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

____ Further Medical Care ____ Personal ____ Changing Physicians
____ Insurance Eligibility/Benefits ____ Legal Investigation or Action ____ Coordination of Care
____ Other (Specify): _____

I understand that I have the right to:

- Inspect or copy the information to be used or disclosed.
- Receive a copy of this authorization
- Revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may no longer be protected by federal privacy regulations. I understand that my healthcare and payment for my healthcare will not be affected if I do not sign this form

Unless Otherwise revoked, this authorization will expire on: _____ or for one year from the date signed.

SIGNATURE OF PATIENT: _____ DATE: _____

_____ _____
Signature of personal representative, person authorized by patient, or other legal authority | **Relationship/legal authority**

_____
Ryon Medical Witness