753 Maleta Lane
Suite 101G
Castle Rock, CO 80108

BRIGID
MEDICAL, LLC

P: 720-770-3919
F: 720-538-3001
BrigidMedical@pm.me

Release of Information

Authorization for Use/Disclosure of Information

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form.

I, _____ with date of birth _____, voluntarily consent to and authorize Brigid Medical, LLC, whose office information is listed in the letterhead, to release/exchange by phone, fax, email, or mail my PHI with:

_____ Practice Name

_____ Provider Name

_____ Practice Email

_____ Practice Address

_____ Office Number

_____ Office Fax

Reason/Purpose for Disclosure:

- ☐ Collaboration
- ☐ Continuation of Care and Treatment
- ☐ Legal
- ☐ Other _____
- ☐ Insurance

The PHI to be disclosed includes the following:

- ☐ Assessment Information
- ☐ Diagnoses
- ☐ Treatment Planning Notes
- ☐ Progress and Treatment Notes
- ☐ Medication(s)
- ☐ Results of Psychological Testing
- ☐ Recommendations
- ☐ Psychiatric Evaluation
- ☐ Other: _____

Release Expires:

- ☐ One Year from Date of Signature(s)
- ☐ Specified Date: _____

By signing below, I acknowledge that the above information about me may be released, discussed, or disclosed. I also understand that I may revoke this authorization at any time and must do so in writing and present written revocation to my provider.

_____ Patient Name	_____ Patient Signature	_____ Date
_____ Parent/Guardian Name	_____ Parent/Guardian Signature	_____ Date
_____ Provider Name	_____ Provider Signature	_____ Date

Notes:

Date Records Released: _____

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Notes:

Date Records Released: _____