MARK LEIFESTE, M.D.

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Boulder, CO 80303
Phone: (303) 449-6577
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Authorization for Medical Release of Information From and To Mark Leifeste, M.D.

Patient Name:_____Birth date:_____

I request and authorize Mark Leifeste, MD to release the health care information described below to:

Name: _____at phone:_____

Address:_____

City, State:_____Zip code:_____

The above named is also authorized to release information to Dr. Leifeste.

This request and authorization applies to all the following protected health information: psychiatric evaluation and treatment, medical, academic, or psychological information, and:

(Circle include or exclude for each of the following)

Include or Exclude: My health information related to drug or alcohol abuse

Include or Exclude: Psychotherapy notes

Purpose of this use/disclosure: psychiatric treatment planning
(and/or other: _____).

Authorization expires in two years or on the following date: _____

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Dr. Leifeste.

I understand that Dr. Leifeste may not condition treatment or eligibility for benefits on my signing this authorization. I understand that information disclosed based on this authorization may be subject to further disclosure by the recipient, and no longer protected by federal privacy regulations.

Signature (patient): _____

Date: _____

Parent (if minor patient): _____

I have received a copy of this signed authorization: (please initial) ____yes ___no