AUTHORIZATION TO RELEASE MEDICAL RECORDS

Circle Clinic:

Downtown Denver	**Highlands Ranch**	**Thornton**
1515 Wazee Street	200 West Countyline	3655 East 104th

Patient Name (Print): ____

Responsible Party Name (Print): __________________________ Relation: ____________

Type of information to be released or disclosed:

X-Ray Films _______ Urgent Care Visit _______ Labs _______

Substance/Drug Abuse _______ AIDS/HIV/STD's _______

Psychological/Psychiatric Conditions _______ Other as Described ______________

I authorize AfterOurs to release my medical records to the following organizations: ____, as described above. I understand that the disclosure of such information carries the potential for unauthorized persons to use my information, which may not be protected by Federal confidentiality laws.

Patient or Responsible Party Signature: ___________________ Date: ________

AfterOurs Urgent Care Employee: _______________________ Date: ________