Rutledge Psychiatry, Professional LLC
RutledgeMD.com
Phone: 720-589-0528
Fax: 720-981-5281
8340 Sangre de Cristo Rd
Suite 209
Littleton, CO 80127

Release of Information

I, _____(name) born on _____ (date of birth) consent for Rutledge Psychiatry, Professional LLC to **share information with and receive information from:**

Name of former provider/primary care/family member/other:

_____

Full Address:_____

Phone Number:_____ Fax Number: _____

Including:

- ☐ Diagnoses
- ☐ Medications
- ☐ Treatment Summary
- ☐ Laboratory Results
- ☐ Mental Health Treatment
- ☐ Substance Abuse Treatment
- ☐ HIV/AIDS Treatment
- ☐ Other:

For the purpose of (circle one):___coordination of care / transfer of records / other_____

This notice will expire one year from the date below, or else on: _____

I understand that I have the right to revoke this authorization, in writing at any time. Such revocation will not apply to any information that has been shared prior to Rutledge Psychiatry, Professional LLC receiving my request.

I understand that treatment will not be refused depending on my signing this consent.

I understand that the information disclosed to this recipient may no longer be protected by federal and state laws regarding confidentiality

☒_____

Signature Date