



Rutledge Psychiatry, Professional LLC
 RutledgeMD.com
 Phone: 720-981-5281
 Fax: 888-981-6763
 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:

- | | |
|---|--|
| <input type="checkbox"/> Diagnoses | <input type="checkbox"/> Mental Health Treatment |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> HIV/AIDS Treatment |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Other: |

For the purpose of (circle one): ___ coordination of care / transfer of records / other _____

This notice will expire upon termination of treatment, 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