John R. Tarr, M.D., Prof. LLC

Child, Adolescent, and Family Psychiatry

8090 W. Progress Circle
Littleton, CO 80123-1269

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AUTHORIZATION TO REQUEST/RELEASE INFORMATION

I,____________________________________, _____________________

Patient Name Date of Birth

Hereby authorize John R. Tarr, M.D., Prof. LLC, to obtain information from or release information to:

____

Provider/Agency

____

Address

____

City State Zip Code

____

Phone Fax

Information to be released:

[ ] All Medical and Mental Health Information

[ ] Only specific information stated here:___________________________________

Authorization: I certify that this request has been made voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has been taken to comply with it. I understand that this consent will expire upon________, or if left blank, in one (1) year. I hereby release the provider from any liability, which may result from furnishing the information requested as authorized in the release. Redisclosure of my medical records may not be accomplished without my further consent. Copy of this authorization is considered as valid as the original.

________________________________ ________________________________

Signature of Patient (15 years or older) Parent/Legal Guardian (if patient under 15)

________________________________ __________________________

Witness/Title Date

Colorado Law states that if a patient is 15 years old or older, the patient must sign the Release of Information.