

POWERS MEDICAL KEITH O, BODRERO, D.O.  
6080 N. CAREFREE  
COLORADO SPRINGS, CO 80922

## **INFORMATION RELEASE FORM**

To Our Patients:

Your privacy is very important to us. In order for us to protect your privacy we are asking each of our patients to take a moment to complete and sign this short release form. Thank you for helping us protect your privacy. Please initial next to appropriate name and sign below.

### **Information Regarding my Appointment May be released to:**

\_\_\_\_\_ - My Spouse \_\_\_\_\_  
Name of Spouse

\_\_\_\_\_ - My Children \_\_\_\_\_  
Name(s) of children

\_\_\_\_\_ - Roommate \_\_\_\_\_  
Roommate

\_\_\_\_\_ - Other \_\_\_\_\_  
Name of other

\_\_\_\_\_ - Answering Machine

\_\_\_\_\_ - Do Not Disclose my Appointment Information except to me.

### **Information Regarding my Lab Results May be released to:**

\_\_\_\_\_ - My Spouse \_\_\_\_\_  
Name of Spouse

\_\_\_\_\_ - My Children \_\_\_\_\_  
Name(s) of Children

\_\_\_\_\_ - Roommate \_\_\_\_\_  
Roommate

\_\_\_\_\_ - Other \_\_\_\_\_  
Name of Other

\_\_\_\_\_ - On Answering Machine

\_\_\_\_\_ - Do Not Disclose my Lab Result Information except to me.

**Information Regarding my Insurance and Payments Due, Information May be released to:**

\_\_\_\_\_ - My Spouse \_\_\_\_\_  
Name of Spouse

\_\_\_\_\_ - My Children \_\_\_\_\_  
Name(s) of Children

\_\_\_\_\_ - Roommate \_\_\_\_\_  
Roommate

\_\_\_\_\_ - Other \_\_\_\_\_  
Other

\_\_\_\_\_ - On Answering Machine

\_\_\_\_\_ - Do Not Disclose my Insurance or Money Information except to me.

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date