

Colorado Springs Family Practice

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AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

- All my health information maintained at this facility.

Circle, Include, Exclude for each of the following

Include or Exclude: My health information related to drug abuse

Include or Exclude: My health information related to alcohol abuse

Include or Exclude: My health information related to HIV/AIDS

Include or Exclude: My health information related to psychological or psychiatric conditions including psychotherapy notes

Include or Exclude: My health information related to sexually transmitted disease

- My health information relating to the following treatment or condition: _____

My health information for the date(s): _____

Other: _____

Requesting records from:

Colorado Springs Family Practice, P.C.
2960 N. Circle Dr, Suite 200
Colorado Springs, CO 80909
Phone (719) 634-8891 Fax (719) 634-1897

You may disclose this information to:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

Reasons for this authorization (check all the apply):

- at my request
 other (specify) _____

- Check here only when Colorado Springs Family Practice requests this authorization for marketing purposes
 Check here only when Colorado Springs Family Practice will get something of value for providing health information for marketing purposes.

This Authorization ends:

- When the following event occurs: _____
 On date: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- o To take part in a research study, or
- o To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I do, It will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- o Fill out a revocation form, the form is available from the office, or
- o Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or legally authorized individual signature Date Time

Printed name if signed on behalf of the patient Relationship to Patient