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:*_____

You may disclose this information to:
Colorado Springs Family Practice, P.C.
2960 N. Circle Dr, Suite 200
Colorado Springs, CO 80909
Phone (719) 634-8891 Fax (719) 634-1897

Requesting records from:
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:

- To take part in a research study, or
- 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:

- Fill out a revocation form, the form is available from the office, or
- 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