ENDOCRINOLOGY SPECIALISTS OF COLORADO

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Authorization to Use or Disclose My Health Information

Patient Name _____ Date of Birth _____

I. **My Authorization**

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

__ All my health information maintained by Dr. _____

(Circle include or 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 mental health conditions, including psychotherapy notes

__ My health information relating to the following treatment or conditions:_____

__ My health information for the date(s):_____

__ Other: _____

You may disclose this health information to:

Name (or title) and organization _____

Address:_____ City:_____ State:_____ Zip_____

Reason(s) for this authorization (check all that apply)

__ at my request

__ other (specify)_____

This authorization ends:

__ on (date)_____ or when the following event occurs_____

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 and 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 sicnature | Date | Time

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal ghuardian, personal representative, ect.)