Authorization to Use or Disclose My Health Information

Requesting records from: Name:_____Address:_____
Phone:_____Fax:_____

Patient name: _____ Date of birth:_____

Previous name: _____

I. My Authorization

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

□ All my health information maintained by the above-named practice

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

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

I specifically authorize disclosure of the following conditions (check all that apply):

□ Drug abuse □ Alcohol abuse □ HIV/AIDS □ psychological or psychiatric conditions, including psychotherapy notes

You may disclose this health information to:

Name (or title) and organization PEDIATRICS AT THE MEADOWS PC_____

Address: 2352 MEADOWS BLVD SUITE170_____City CASTLE ROCK_____State CO_____Zip 80109

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

□ At my request
□ Check here only when _____requests the authorization for marketing purposes
□ Check here only if this authorization involves the sale of protected health information
□ Check here only when _____ will get anything of value for providing health information (other than copying costs)
□ Other
(specify)_____

This authorization ends*: □ On (date): _____
□ When the following event occurs: _____
If no end date is provided, this authorization will expire one year from the date of signing

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). 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 revoke this authorization, it would 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 be able to redisclose 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 (parent, legal guardian, personal representative, etc.)