Elizabeth Family Health, P.C.

P.O. Box 1272
Elizabeth, CO 80107

Telephone: (303)646-4071
Facsimile: (303)646-0908

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 apply):

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

(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 psychological or psychiatric conditions, including psychotherapy notes

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

☐ 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) _____

_____

☐ Check here only when Elizabeth Family Health requests the authorization for marketing purposes

☐ Check here only when Elizabeth Family Health will get something of value for providing health information for marketing purposes

This authorization ends: ☐ On (date) _____ ☐ when the following event occurs_____

II. My Rights

I understand I do not have to sign this authorization form 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.

******FEES FOR COPIES: Federal and state law permits a fee to be charged for copying of patient records. This facility has contracted with Verisma to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.**

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, POA