

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Name of office where records are: _____

Address: _____

Phone: _____

Fax: _____

Name: _____

Previous Name: _____

Date of Birth: _____

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.

CHECK TO EXCLUDE:

My health information related to drug abuse _____

My health information related to alcohol abuse _____

My health information related to psychological or psychiatric conditions, including psychotherapy notes _____

My health information relating only to the following treatment/conditions: _____

My health information for the dates: _____

Other: _____

Disclose information to:

Cornerstone Family Practice
1411 S. Potomac St. #300
Aurora, CO 80012 303-531-4910 phone, 303-309-3733 fax

Reason for this authorization (check all that apply):

At my request

Other (specify) _____
(includes authorization for marketing purposes)

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 continuity of care issues mandate

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice used 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, 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: _____

Printed name if other than patient _____ Relationship to patient _____