# Authorization to Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____

Previous Name(s), Alias(es): _____

## I. My Authorization

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

☐ All my/my child's health information maintained by _____
Name of health care facility and/or physician

_____
Mailing Address City State Zip Code

(Indicate include or exclude for EACH of the following)

| | | |
|---|---|---|
| ☐ Include or | ☐ Exclude: | My/my child's health information related to drug abuse |
| ☐ Include or | ☐ Exclude: | My/my child's health information related to alcohol abuse |
| ☐ Include or | ☐ Exclude: | My/my child's health information related to HIV/AIDS |
| ☐ Include or | ☐ Exclude: | My/my child's health information related to psychological or psychiatric conditions, including psychotherapy notes |

☐ My/My child's health information related to the following treatment or condition: _____

☐ My/My child's health information for the date(s): _____

☐ Other: _____

**You may disclose this health information to:**

☐ Pediatrics at Cherry Creek
300 South Jackson Street, Suite 300
Denver, CO 80209
FAX: (303) 377-9954

☐ Pediatrics at Stapleton Plaza
3401 Quebec Street, Suite 3900
Denver, CO 80207
FAX: (303) 388-4777

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

☐ at my request

☐ other (specify) _____

_____

_____

☐ check here only when _____ requests the authorization for marketing purposes

☐ check here only when _____ 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 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 authorizaton. 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.

_____ _____ _____
Parent or legally authorized individual signature Date Time

_____ _____
Printed name, if signed on behalf of the patient Relationship (parent, legal guardian, personal representative,etc.)