



13650 E. Mississippi Ave. Suite 100B Aurora, CO 80012  
303-695-1338 (phone) \* 303-695-8814 (fax)

### Authorization to Use or Disclose My Health Information

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

#### I. Authorization

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

- 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(s) or condition(s): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

My health information for the date(s): \_\_\_\_\_

Other: \_\_\_\_\_

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

Name (or title) and Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

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

- At my request \_\_\_\_\_
- Other (specify) \_\_\_\_\_

Check here only when Rocky Mountain Urgent Care, PC requests the authorization for marketing purposes

Check here only when Rocky Mountain Urgent Care, PC 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
- 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.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

#### III. Acknowledgement

I acknowledge that in accordance with Colorado Department of Public Health and Environment a fee may be charged for copies of medical records. The charge is \$14.00 for the first ten pages and .33 cents for each additional page. There is no charge for physician to physician record transfers.

#### IV. Signature

\_\_\_\_\_  
Patient or Legally Authorized Individual Signature / Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient