Name of previous doctors office: _____ Phone#_____ Fax#_____

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 relation to the following treatment or condition: _____

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

□ Other:_____

You may disclose this information to:

Name (or title) and organization Founders Family Medicine & Urgent Care Phone/Fax#: 303-688-8666/303-688-8260

Address: 4386 Trail Boss Dr. City Castle Rock State CO Zip 80104

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

□ at my request

□other (specify)_____

_____

_____

□ check here only when records are being requested 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 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. This form is available from the office, or
- Write a letter to the office.

Once the office discloses health information, the person or organization the receives it may re-disclose 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.)

Version 1.0