AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described below:

The following individual or organization is authorized to disclose the information:

_____

_____

_____

The following individual or organization is authorized to receive the information:

[ ] Colleen Begley, MD
[ ] Dawna Eastman-Gallo, M.D.
[ ] Kimberly Roos, M.D
[ ] Andrea Burgess, M.D.

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Lafayette, CO 80026
Phone (303) 665-6016
Fax (303) 665-0121

The information will be disclosed for the following purposes:

_____

The information to be disclosed:

[ ] Specific condition(s)_____ [ ] Specific dates of treatment_____
[ ] Tests/Lab results only_____ [ ] Other_____
[ ] All medical records generated by this provider

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and substance abuse.

Re disclosure: I understand that any disclosure of information carries with it the potential for re disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Expiration: This authorization will expire on _____ (date, event, or condition).

_____ _____
Signature of Patient or Representative | Date

_____ _____
Patient Name | Date of Birth

_____ _____
Maiden/Other Names Used | SS#

_____ _____
Name of Personal Representative (if applicable) | Relationship to Patient