Rocky Mountain Family Medicine
13650 E. Mississippi Ave. Suite 120 Aurora, CO 80012
303-695-8684 (phone) * 303-597-0191 (fax)
Corporate Office

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 Family Medicine, PC requests the authorization for marketing purposes

☐ Check here only when Rocky Mountain Family Medicine, 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. There is no charge for medical records less than 15 pages and physician to physician record transfers. Charges of $16.50 will be assessed for pages16 thru 26 there after, .75 cents per page 27 thru 40, and .50 cents per page for the 41 additional.

IV. Signature

_____ _____ _____

Patient or Legally Authorized Individual Signature / Relationship **Date** **Time**

_____

Printed name if signed on behalf of the patient