

Rocky Mountain Urgent Care, PC
Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____

My Authorization

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

- All health information maintained by Rocky Mountain Urgent Care, PC including
- | | |
|---|---|
| <input type="checkbox"/> Drug Abuse (if any) | <input type="checkbox"/> AIDS/HIV (if any) |
| <input type="checkbox"/> Substance Abuse (if any) | <input type="checkbox"/> Psychological/Psychiatric Conditions |

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

Other: _____

You may disclose this information to:

Name or Organization: _____

Address: _____

Fax Number: _____

Reason for this authorization is:

- At my request Other _____

*This authorization expires one year from the date of signature or on _____
A copy of this authorization may be utilized with the same effectiveness as the original.*

My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing or by completion of a revocation form available from the office. 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 and privacy laws may no longer protect it.

Acknowledgment

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 .25 cents for each additional page. There is no charge for physician to physician record transfers.

Signature

Patient or legally authorized signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian)