DERMATOLOGY CENTER OF STEAMBOAT SPRINGS Fax 970-879-4527
940 Central Park Dr 210 Phone 970-871-4811
Steamboat Springs, CO 80487-8816

Patient name _____ Date of Birth ____/____/_____

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

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 conditions, Including psychotherapy notes

Include my health information relating to the following treatment or condition:

_____

Include my health information for the date(s) _____

Other:_____

You may disclose this health information to:

Name (or title) and organization:_____

Address:_____

street city state zip code

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

☐ At my request I understand it could take up to two weeks to receive The records requested.

☐ Other (specify)_____

_____

This authorization ends:(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 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. The form is available from the office, or write a letter to the office.

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

_____ _____

Patient of legally authorized individual signature Date and Time

_____ _____

Printed name if signed on behalf of the patient Relationship(parent, legal guardian, etc)