DERMATOLOGYCENTER
STEAMBOAT SPRINGS

940 Central Park Dr, Ste 210
Steamboat Springs CO 80487-8816
Office: 970.871.4811
Fax: 970.879.4527

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 Dermatology Center of Steamboat Springs
(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

Include my health information relating to the following treatment(s) or condition(s): _____

_____

Include my health information for the following dates: _____
Other: _____

You may disclose this health information to:
Name (or title) and organization: _____
Address: _____

_____

****email address required for encrypted electronic delivery**** ****payment of $9.90 required for tracked Priority Mail****

Reason(s) for this authorization (check all that apply):
____ At my request
____ Other (Specify) _____

_____

I understand it could take up to two weeks to receive the records requested.

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
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 Dermatology Center of Steamboat Springs 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. The form is available in the office; or
Write a letter to the office.

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

_____ _____
Patient or legally authorized Individual's signature Date and Time

_____ _____
Printed Name if signed on behalf of the patient Relationship (parent, guardian, personal representative, etc.)