SURGICAL SPECIALISTS OF COLORADO, P.C.

Authorization to Use or Disclose My Health Information

Patient name:_____ Date of birth: _____

Previous name if used: _____

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 or psychiatric conditions, including psychotherapy notes

☐ My health information relating to the following treatment or condition: _____

You may disclose this health information to:

Name (or title) and organization:

Address _____ City _____State_____ Zip _____

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

☐ At my request

☐ One time only

☐ Other (specify)_____

_____

This authorization ends:

☐ when the following event occurs_____

☐ on (date)_____

(one year from date of signature)

II. My Rights

I understand I do not have to sign this authorization form 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 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 from 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 signature Date

_____ _____

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

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