PARKER FAMILY CARE

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous Physician or Practice Name: _____

Previous Physician Phone Number: _____ Previous Physician Fax Number: _____

I. My Authorization

You may use or disclose the following health care information (circle all that apply):

All my health information maintained by the above-named practice.

(Circle "include" or "exclude" for **each** of the following)

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/psychiatric conditions, including psychotherapy notes: **Include** or **Exclude**

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

My health information for the date(s): _____

Other: _____

You may disclose this health information to: ***Parker Family Care***

10259 S. Parker Road, Suite 200

Parker Colorado 80134

Phone: 303-805-2273

Fax: 303-805-2287

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

At my request

Other (specify)

_____

This authorization ends: On (date) _____

When the following event occurs _____

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.

Would you like to pick up the hard copy of your records once we have received and uploaded them to your chart? Yes___ No___

_____ _____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

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