AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

must complete:

*Patient's Name:____

Previous Name:____

*Date of Birth:____

*Name of office where records are currently:______________________________

Address:____

*Phone:____________________ *Fax:__________________________

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.

CHECK TO EXCLUDE:

My health information related to drug abuse_______

My health information related to alcohol abuse_____

My health information related to psychological or psychiatric conditions, including psychotherapy notes_______

☐ My health information relating only to the following treatment/conditions:________________

☐ My health information for the dates:______________________________

☐ Other:____

Disclose information to:

Cornerstone Family Practice
1411 S. Potomac St. #300
Aurora, CO 80012 303-531-4910 phone, 303-309-3733 fax

Reason for this authorization (check all that apply):

☐ At my request

☐ Other (specify)____
(includes authorization for marketing purposes)

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 continuity of care issues mandate

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the above named practice used 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, 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 signaure__________________________ *Date:______________

*Printed name if other than patient______________________________ *Relationship to patient__________