AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Name of office where records are: **Cornerstone Family Practice**
1411 S. Potomac St. #300
Aurora, CO 80012 303-531-4910 phone, 303-309-3733 fax

Name:____

Previous Name:____

Date of Birth:____

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:
Organization name:______________________________________

Address:____

Phone:____

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 signature_______________________Date:______________

Printed name if other than patient___________________________Relationship to patient__________