Name of Practice Requesting records from: _____

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

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: _____

☐ My health information for the date(s):

☐ Other: _____

You may disclose this health information to:

Castle Valley Children's Clinic 970-984-3333 Fax 970-984-0293

820 Castle Valley Blvd. Suite 204 New Castle, CO. 81647

Reason(s) for this authorization (check 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.

_____ _____ _____

Parent /Patient or legally authorized individual signature | Date | Time

_____ _____

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