

Authorization for Use or Disclosure of Protected Health Information

Summary: This form is used by the patient to request a release of Protected Health Information (PHI) for specific purposes. A copy of this form, once signed, is for the patient to keep.

I authorize my physician and/or administrative and clinical staff to (check all that apply):

use the following PHI, and/or

disclose the following PHI to **Name of entity or class of persons to receive information**:

[Specifically and meaningfully describe the PHI to be used or disclosed such as date of service, type of service, level of detail to be released, origin of information, etc.]

This PHI is being used or disclosed for the following purposes:

[List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.]

This authorization shall be in force and effect until: _____

Specify (1) date or (2) event that relates to the patient or the purpose of the use or disclosure at which time this authorization to use or disclose this PHI expires. ("End of the research study" and "none" is acceptable for authorization for research purposes.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 7720 S. Broadway, Suite 480, Littleton, CO 80122. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. **[If applicable because the authorization is obtained for marketing purposes.]**

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority