AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

PATIENT NAME: ____ DATE OF BIRTH: ______________________

ADDRESS: ____ CITY: __________________ STATE: ________ ZIP: ________

SOCIAL SECURITY #: ___________________________________ PHONE #: ____

I HEREBY AUTHORIZE AND REQUEST MEDICAL INFORMATION TO BE RELEASED FROM:

NAME OF FACILITY OR OFFICE: ____

ADDRESS: ____ CITY: __________________ STATE: ________ ZIP: ________

PHONE #: ____ FAX #: ____

YOU MAY USE OR DISCLOSE THE FOLLOWING HEALTHCARE INFORMATION (CHECK THOSE THAT APPLY):

- ☐ My entire health record maintained by the above-named provider FOR THE PAST 3 YEARS *plus* the following:
  - Last colonoscopy, mammogram, DEXA, and pap smear results
  - Vaccination record
  - Pulmonary Function Tests, Echocardiograms, EKG, Sleep Studies, and Stress Test Results
  - Consult Notes
- ☐ My health information related to the following condition: ____
- ☐ My health information related to the following dates: ____
- ☐ Please exclude information related to:____

YOU MAY DISCLOSE THIS INFORMATION TO:

SALIDA FAMILY MEDICINE PHONE: 719-536-3583

320 EAST 1ST STREET FAX: 719-539-3028

SALIDA, CO 81201

THIS AUTHORIZATION ENDS: Date: ________________ OR Reason:____

MY RIGHTS:

I understand I do not have to sign this authorization form to receive health care benefits at Salida Family Medicine. By signing below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization. My health information may include patient history, office notes, test results, radiology studies, referrals, consuls, billing records, consult notes. I further understand that my medical record may include information about treatment of communicable diseases such as sexually transmitted disease or HIV, mental health conditions, alcohol or substance abuse treatment or diagnosis, and genetic testing.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization at my request.

SIGNATURE OF PATIENT OR REPRESENTATIVE:_________________________________ DATE: __________

DESCRIPTION OF REPRESENTATIVES AUTHORITY: ____

Updated 10/2017