

Name of Practice and phone number: \_\_\_\_\_ (where your records currently reside/previous physicians office)

**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:**

Name (or title) and organization: **Lowry Pediatrics**

Address: **8190 E. 1st Ave #100** City: **Denver** State: **CO** Zip: **80230**

**Reason(s) for this authorization (check all that apply):**

- At my request
- Check here only when **Lowry Pediatrics** requests the authorization for marketing purposes
- Other (specify) \_\_\_\_\_
- Check here only when **Lowry Pediatrics** will get something of value for providing health information for marketing purposes

**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.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative, etc.)