Colorado Ophthalmology Associates, P.C.
Authorization to Use or Disclose My Health Information

Patient Name: _____ **Date of Birth:** _____

Releasing person/practice name: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

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) of person/practice to receive information)

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Reason(s) for this authorization (check all that apply):
☐ **transferring care to another office**
☐ **at my request**
☐ **other (specify)** _____

This authorization ends on (mo/day/year): _____

MY RIGHTS

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).

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.

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 signature **Date** **Time**

_____ _____
Printed Name if signed on behalf of the patient **Relationship (parent, legal guardian, etc.)**