755 South Perry Street, Suite 100
Castle Rock, CO 80104
(303) 688-8989
FAX (303) 688-3482

Castle Rock Family Physicians

Authorization for Use, Disclosure or Release of Protected Health Information (PHI)

(Send Records to Castle Rock Family Physicians)

Patient name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Previous name(s) Used: _____

Phone Number: _____ Fax Number: _____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure.

Name / Physician / Organization: _____
Address: _____ City _____ State _____ Zip _____
FAX: _____ Phone: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   - ❑ Complete health records
   - ❑ Physical exam
   - ❑ Immunization record
   - ❑ Lab results / x-ray reports
   - ❑ Consultation reports
   - ❑ Other (please specify): _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to, used by, or released to the following individual or organization:

   Castle Rock Family Physicians
   755 South Perry Street, Suite 100
   Castle Rock, CO 80104

   Fax: 303-688-3482

   For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

7. If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:

   Attn: Privacy Officer
   Facility of Record in 2. above

_____ _____ _____ _____
Signature of patient or legal representative | Date | Signature of witness | Date

_____
Printed name if signed on behalf of the patient AND relationship (parent, legal guardian, personal representative, etc.)

Please note: This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC-3701.243) and federal law 42 CFR, Part II.