

BOULDER ORTHOPEDICS, PC

933 Alpine Avenue
Boulder, CO 80304
Phone (303) 449-2730
Fax (303) 449-5821

Authorization to Use or Disclose My Health Information

Patient's Name _____ Birthdate: _____
(Please print legibly)

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 Boulder Orthopedics.
(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 dates(s): _____

Other: _____

You may disclose this health information to:

Name (or title) and organization _____

Address: _____

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

- at my request
- check here only when Boulder Orthopedics requests the authorization for marketing purposes
- other (specify) _____
- check here only when Boulder Orthopedics 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 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. To revoke this authorization, write a letter to our 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 patient

Relationship (parent, guardian, personal representative, etc)