Authorization for Use or Disclosure of Health Information

Patients Name _____ Date of Birth _____

Name of Person Requesting Information (If other then patient) _____ Relationship _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called "protected health information" under a federal health privacy law as described below:

Specific Description of the Information to be Used or Disclosed including dates of service:

Chose one of the following:

- ♣ All dates of service or Dates from _____ to _____

Chose one of the following:

- ♣ Regarding the following illness(es) or injury(ies): _____
- ♣ Including all illnesses, injuries and well exams.

Chose all that apply:

- ♣ All Clinical Records (May include, but not limited to: office notes and exams, phone calls, lab results, diagnostic testing, specialist consultation, and prescription refill requests.)
- ♣ All Administrative Records (May include, but not limited to: Demographic and insurance information and referral information.)
- ♣ All Billing Records

Chose all that apply:

- ♣ Include all records
- ♣ Omit records of any drug/substance abuse (if applicable)
- ♣ Omit records of any mental health conditions (if applicable)
- ♣ Omit records of and AIDS/HIV testing or conditions (if applicable)

Additional specific information identifying this information:

Person or Class of Persons to Whom the Use or Disclosure May be Made:

Name of Individual/Organization: **Dr. William Dickey**

Address: **9397 Crown Crest Blvd**

City, State & Zip: **Parker CO, 80138**

Phone Number: **303-840-9690**

Fax Number: **303-840-9617**

Purpose for Release (Choose One):

- ♣ Records for Specialist/Consultation
- ♣ Transferring Care to Dr. William Dickey
- ♣ Other (Please Specify) _____

Please forward the records as follows:

- ♣ Mail to Dr. William Dickey
- ♣ Fax to Dr. William Dickey
- ♣ Phone Conversation with Dr. William Dickey
- ♣ I will pick up records at Office

Expiration of Authorization:

- ♣ None
- ♣ On the following date_____
- ♣ At the time of the following event: _____

By signing below, I acknowledge the following:

- I hereby authorize _____**,** its employees and owners to make use or disclose my health information as indicated above.
- I understand that I may revoke this authorization at any time by giving Dr. Dickey written notification of such revocation. However, if I chose to do so, I understand that my revocation will not affect any actions taken by the practice before receiving my revocation.
- I understand that I may reference Dr. Dickey's Notice of Privacy Practices for additional information on Protected Health Information.
- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.
- I also understand that a copy of this authorization may be utilized with the same effectiveness as the original.
- I understand that Dr. Dickey provides the first copy of my records at no charge, but there may be a charge for additional copies. This charge will be set using the Colorado Bar Association rate.

_____ _____

Authorized Signature Date

(Individuals aged 18 and over must sign this release themselves. Parents must sign for children aged 17 and under)