

**Authorization to Use or Disclose My Health Information**

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name: \_\_\_\_\_

**Requesting records from:**

- Hampden Medical Group, 221 E Hampden Ave, Englewood, CO 80113
- \_\_\_\_\_  
\_\_\_\_\_

**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 (**please circle to include or exclude 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:**

- Hampden Medical Group, 221 E Hampden Ave, Englewood, CO 80113
- Name (or title) and organization \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

- at my request
- other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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. 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.)