

Authorization for Doctor: _____ to Use or Disclose My Health Information

Doctors Telephone #: _____ Doctors Facsimile #: _____

Patient name: _____

Date of birth: _____ SSN: _____

I. My Authorization

You, Doctor: _____, may use or disclose the following health care information:

- All my health information maintained by you
- 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) and organization: **Corneal Consultants of Colorado, P.C.**
Address: **8381 SouthPark Lane** City: **Littleton** State: **CO** Zip: **80120**
Telephone: **303 730-0404** Facsimile: **303 730-6163**

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 receive treatment. However, I may be required to sign this 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 at any time, in writing. If I do, it will not affect any actions already taken, based upon this authorization; uses and disclosures already made cannot be taken back. 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.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient or legally authorized individual signature Date Time

Patient is unable to sign because of: _____
Age of minor or reason for patient's inability to sign

Printed name if signed on behalf of the patient Relationship & Authority (parent, legal guardian, personal representative, etc.)

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

- I consent to have the above information released.
- I do not consent to have the above information released.

Patient or legally authorized individual signature Date Time

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

- I consent to have the above information released.
- I do not consent to have the above information released.

Patient or legally authorized individual signature Date Time