# AUTHORIZATION TO USE OR DISCLOSE MY HEALTH INFORMATION

Name of Practice:_____

Patient name:_____ Date of birth:_____

**My Authorization**

**You may use or disclose the following health care information (check all that apply):**

- o All my health information maintained by the above named practice
  - Include or Exclude: My health info related to drug abuse
  - Include or Exclude: My health info related to alcohol abuse
  - Include or Exclude: My health info related to HIV/AIDS
  - Include or Exclude: My health info related to psychological or psychiatric conditions, including psychotherapy notes
- o My health info relating to the following treatment or condition:_____
- o Other:_____

**I. You may disclose this health information to:**

Kidney Associates of Colorado, P.C.
850 E. Harvard Ave Suite 565
Denver, CO 80210
Ph # (303) 777-3333
Fax # (303) 733-4441

**II. Reason(s) for this authorization :**

- o At my request
- o Other

This authorization ends……on (date)_____

…….when the following event occurs_____

**III. 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 info 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 forms are 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.

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_____ _____ _____

Patient or legally authorized signature Date Time