Aspen Medical Care, PC
Authorization to Use or Disclose My Health Information

Patient name: ____ Date of Birth: ________________

I. **My Authorization**

Please provide to Aspen Medical Care, PC at 611 W. Main Street, Aspen, CO 81611, 970-920-0104, 970-920-0124 (fax) the following health care information (check all that apply):

□ All my health information maintained by ____

(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 date(s): ____

□ Other: ____

The following is authorized to disclose this health information to Aspen Medical Care, PC:

Name (or title) and organization____

Address: ____

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

□ at my request

□ other (specify)__________________________

____

____

□ check here only when Aspen Medical Care requests the authorization for marketing purposes

□ check here only when Aspen Medical Care will get something of value for providing health information for marketing purposes

This authorization ends: □ on (date) ____________________________(not longer than 1 year)

□ 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 based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once health information is disclosed, 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.)