

# ASPEN MEDICAL CARE, PC

## Authorization to Use or Disclose My Health Information

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### I. My Authorization

Aspen Medical Care, PC may use or disclose the following health care information (check all that apply):

- All my health information maintained by the above practice  
(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: \_\_\_\_\_

### You may disclose this health information to:

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 by Aspen Medical Care, PC based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Once Aspen Medical Care, PC 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  
etc.)

\_\_\_\_\_  
Relationship (parent, legal guardian, personal representative,  
etc.)