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 101 Founders Place, Suite 109, 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, personalrepresentative, etc.)