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

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