Aspire for Women Obstetrics and Gynecology (A Member of OB/GYN Affiliates)
125 Inverness Dr E Ste 210, Englewood, CO 80112 | Phone: (303) 221-1490 | Fax: (303) 221-1009
Leslie T. Scariano, MD | Grace Holub, MD

Authorization to Use or Disclose My Health Information

PATIENT INFORMATION (please print):

Name:_____ Date of Birth_____

I authorize _____ to use or disclose my protected health

information at my request, including copies of my medical record to the address/facility listed below:

Name of Provider/Facility: Aspire for Women Obstetrics and Gynecology, a Member of OB/GYN Affiliates

Address: 125 Inverness Dr E Ste 210, Englewood, CO 80112 Phone: (303) 221-1490 Fax: (303) 221-1009

Records Transferred From

Physician/Practice:_____Phone_____

Address_____

Purpose of disclosure (please specify as required by HIPAA regulations):

____ Continuing care w/another physician/hospital ____ Transfer of care ____ Personal copy

____
Other_____

I specifically authorize disclosure of the following conditions:

____ Drug Abuse ____ Alcohol Abuse ____ HIV/AIDS

____ Psychological/psychiatric conditions, including psychotherapy notes

Information to be released:

____ All my health information

____ My health information relating to the following treatment or condition:_____

____ My health information for the date(s):_____

My Rights

1. I may revoke this authorization at any time by notifying the originating organization noted above in writing.
2. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed .
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
4. I have the right to inspect or copy the information to be used/disclosed as permitted by federal law.
5. I may refuse to sign this authorization and that it is strictly voluntary.
6. Authorization will expire 90 days after signature unless indicated otherwise (insert date):
7. If I do not sign this form, my healthcare and the payment for my healthcare will not be affected.
8. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

_____

_____ Patient or legally authorized individual signature Date

_____

_____ Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)