Boulder Dermatology

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Authorization to Use or Disclose My Protected Health Information

Patient Name: _____Date of Birth: _____

Previous or other name we may have your information under: _____

I Authorize Disclosure of the Following:

Name (or title) and organization: _____

Address: _____

City, State and Zip Code: _____

Fax Number: _____

- All health information maintained by the above named 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 psychological or psychiatric conditions
- My health information relating to the following treatment or conditions: _____
- My health information for the date(s): _____
- Other: _____

You may disclose this health information to / from: **Boulder Dermatology**
400 S McMcaslin Blvd. Ste. 100
Louisville, CO 80027
Fax: (303) 604-6062

Purpose of the Disclosure:

- At my request
- For insurance purposes
- Other (please specify): _____

This authorization ends: On (date): _____

When the following event occurs:
_____

My Rights

I understand I do not have to sigh this authorization in order to get health care benefits. However, I do have to sigh an authorization 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 Boulder Dermatology based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office 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: _____

Print name and relationship: _____