9195 Grant Street, Suite 410
Thornton, CO 80229
Phone: 303-280-2229
Fax: 303-280-0765
www.TCPFIC.com

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the use or disclosure of health information about me as described below:

The following individual or organization is authorized to disclose the information:

____
____
____

The following individual or organization is authorized to receive the information:

Provider (optional):____

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Thornton, CO 80229
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The information will be disclosed for the following purposes:

____

The information to be disclosed:

[ ] Specific condition(s)________________ [ ] Specific dates of treatment___________
[ ] Tests/Lab results only________________ [ ] Other______________________________
[ ] All medical records generated by this provider

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and substance abuse.

Re disclosure: I understand that any disclosure of information carries with it the potential for re disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Expiration: This authorization will expire on __________________ (date, event, or condition).

___________________________________ ____________________________
Signature of Patient or Representative Date

___________________________________ ____________________________
Patient Name Date of Birth

___________________________________ ____________________________
Maiden/Other Names Used SS#

___________________________________ ____________________________
Name of Personal Representative (if applicable) Relationship to Patient