

Name:
Chart:
DOB:



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| | |
|---|---|
| OFFICE USE ONLY Date of Pick up: _____ By: _____ | Fee: Mailed: \$10 _____ Hand-carried: \$10 _____ Fedex: \$20 _____ |
|---|---|

Authorization to Use or Disclose My Health Information

Name of Practice: _____ (Enter name of facility requesting records **from**)
Previous name(s) _____

1A. My Authorization

You may use or disclose the following health care information (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Imaging Reports (X-ray, Stentor) | <input type="checkbox"/> Imaging Pictures |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Imaging Disc (additional fees may apply) | <input type="checkbox"/> Hospital Procedures |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> MRI Disc | <input type="checkbox"/> Physical Therapy Notes |
| | | <input type="checkbox"/> All my health information |

***REQUIRED-** Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical record.

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Include | <input type="checkbox"/> Exclude for alcohol abuse/drug abuse |
| <input type="checkbox"/> Include | <input type="checkbox"/> Exclude for psychiatric/mental health |
| <input type="checkbox"/> Include | <input type="checkbox"/> Exclude for HIV / AIDS |

My Medical reports/notes relating to the following treatment or condition: _____ /Dates _____
(Last 2 years unless otherwise specified)

1B. Imaging pictures or office notes handed to patient from medical areas.

You may disclose this health information to:

Name (or title) and organization _____ (Enter name of facility **receiving** records)
Address: _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> At my request | <input type="checkbox"/> Check here only when [insert physician or clinic name] requests the authorization for marketing purposes |
| <input type="checkbox"/> Other (specify) _____ | <input type="checkbox"/> Check here only when [insert physician or clinic name] will get something of value for providing health information for marketing purposes |

This authorization ends: on (date) _____ (expires after one year)
 when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization form 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 the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office. **OR** Write a letter to the office.

I understand that if the person or entity receiving authorized information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient & may no longer be protected by federal or state law.

Patient or legally authorized individual signature

Date

Time

Staff initials: _____

Printed name if signed on behalf of the patient

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