



AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Care Provider: CarePoint Infectious Disease, PLLC
4500 E. 9th Ave., Suite 740
Denver, CO 80220

Patient Name:	Patient Date of Birth:
Recipient's Name:	Recipient Address:
This Authorization for Use/Disclosure of Protected Health Information on the following: <input type="checkbox"/> Date: __/__/____ <input type="checkbox"/> Event: _____ (If left blank, this Authorization for Use/Disclosure of Protected Health Information will expire 1 year from the signature date stated below).	<input type="checkbox"/> Send by Facsimile to Recipient at: (____) ____ - _____ <input type="checkbox"/> Send a paper copy by United States Mail, Postage Prepaid to the Recipient's address stated above. (If left blank, a paper copy will be provided by United States Mail, Postage Prepaid)

Purpose: I authorize the release of my Protected Health Information for the following specific purpose:
_____.

Authorization for Disclosure of Information: I authorize the disclosure and release of the following Protected Health Information (check the applicable boxes below):

- | | |
|--|--|
| <input type="checkbox"/> All Protected Health Information in the medical record. | <input type="checkbox"/> Provider Orders |
| <input type="checkbox"/> Diagnostic Test Documentation, Assessment and Reports | <input type="checkbox"/> Dictated or written Provider Reports |
| <input type="checkbox"/> Patient History | <input type="checkbox"/> Provider Notes |
| <input type="checkbox"/> Intake Forms and Information | <input type="checkbox"/> Medication Records |
| <input type="checkbox"/> Psychotherapy Notes/Psychiatric Information (Requires Provider Review and Approval) | <input type="checkbox"/> Therapy and Treatment Information |
| Approved: _____(Provider's Signature) | <input type="checkbox"/> Billing Information and Itemized Bills |
| | <input type="checkbox"/> Special forms, letters or documentation |

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information _____ (**INITIALS REQUIRED**).

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned upon this authorization.
3. I may revoke this authorization at any time in writing and delivered to the health care provider at the address stated above, but if I do, my revocation will not have any effect on any actions taken prior to receiving the revocation. Further tails may be found in the Notice of Privacy Practices.
4. If the recipient is not a health plan or healthcare provider, the released protected health information may no longer be protected by federal privacy regulations and may be redisclosed.

- 5. I understand that I may see and obtain a copy of the protected health information described in this form for a reasonable fee and after a request by me, unless otherwise prohibited by law.
- 6. I am entitled to receive a copy of this form after I sign it.

I have read the above and foregoing Authorization for Use and disclosure of Protected Health Information and hereby authorize the disclosure of Protected Health Information as stated. A photocopy or electronic copy of my signature shall be effective as an original signature.

Signature of Patient/Patient's Representative

Date

If signed by Patient's Representative, print name of Patient's Representatives and relationship to patient.

Print Name of Patient Representative

Relationship to the Patient