Pediatric ASSOCIATES of Northern Colorado

1330 Oakridge Drive, #100
Fort Collins, CO 80525
p 970.484.4871
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Authorization To Release My Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize_____
Name Address City State Zip
_____( ) _____( ) _____
Phone Fax

To release information and my medical records as indicated below, to:

Pediatric Associates of Northern Colorado
1330 Oakridge Drive, #100
Fort Collins, CO 80525

I. My Authorization:
You may use of disclose the following health care information (check all that apply):

___ All my 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 HIV/AIDS
Include or exclude: My health information to psychological or psychiatric conditions, including psychotherapy notes.

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

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

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

___ At my request (comments): _____
___ Other (reason): _____

This authorization ends (date): _____

II. My Rights:
I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the entity which was originally authorized to disclose information.

Once this health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws no longer protect it.

_____ _____
Parent or Legally Authorized Individual Signature Date

_____ _____
Print Name and Relationship if Signed on Behalf of Patient Date

Revised: 06/09/2012