

# UROLOGICAL ASSOCIATES OF WESTERN COLORADO

790 Wellington Ave. #202, Grand Junction, CO 81501

Phone (970) 243-3061 Fax (970) 243-8108

## Authorization to Use or Disclose My Health Information

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Previous name(s): \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### I. My Authorization

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

- All my health information maintained by the above named practice  
(Check to include the following)
- My health information related to drug abuse     My health information related to alcohol abuse  
 My health information related to HIV/AIDS     My health information related 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): \_\_\_\_\_ Other: \_\_\_\_\_

You may disclose this health information to:

Name (or title) and organization \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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

- At my request    Check here only when Urology Associates of Western  
 Other    Co. requests the authorization for marketing purposes  
(specify) \_\_\_\_\_    Check here only when Urology Associates of  
\_\_\_\_\_    Western Co. will get something of value for providing  
\_\_\_\_\_    health information for marketing purposes

This authorization ends:    on (date) \_\_\_\_\_  
when the following event occurs \_\_\_\_\_

### II. My Rights

I understand I do not have to sign this authorization 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.

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 \_\_\_\_\_ Time \_\_\_\_\_

Printed Name if signed on behalf of the patient \_\_\_\_\_ Relationship (parent, legal guardian, personal representative, etc.) \_\_\_\_\_