AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Care Provider: **Blue Sky Neurology**
CarePoint, P.C.
499 E. Hampden Avenue, Suite 360
Englewood, Colorado 80113

Patient Name:	Patient Date of Birth:
Recipient's Name:	Recipient Address:
This Authorization for Use/Disclosure of Protected Health Information on the following: ☐ Date: __/__/____ ☐ Event: _____ _____ (If left blank, this Authorization for Use/Disclosure of Protected Health Information will expire 1 year from the signature date stated below).	☐ Send by Facsimile to Recipient at: (_____) _____ - _____ ☐ 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):

- ☐ All Protected Health Information in the medical record.
- ☐ Diagnostic Test Documentation, Assessment and Reports
- ☐ Patient History
- ☐ Intake Forms and Information
- ☐ Psychotherapy Notes/Psychiatric Information (Requires Provider Review and Approval)
  Approved: _____(Provider's Signature)
- ☐ Provider Orders
- ☐ Dictated or written Provider Reports
- ☐ Provider Notes
- ☐ Medication Records
- ☐ Therapy and Treatment Information
- ☐ Billing Information and Itemized Bills
- ☐ 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**