Boulder Women's Care, P.O. Box 17458, Boulder, CO 80308-1458-Mailing address
4745 Arapahoe, Suite 320, Boulder, Colorado 80303-Physical address
Phone: 303-441-0587 Fax: 303-996-0801

Authorization to Use or Disclose My Health Information

Patient name: ______________________________Maiden name:_______________ Date of birth:_______________
Clinic/Doctor who is to release records if other than Boulder Women's Care: _____________________________
____ Dr/Clinic Phone #:_______________

I. <u>My Authorization/Please complete all sections or this could delay release</u>

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

? All my health information maintained by the above named practice, to include anything that could have a bearing on my fertility. **(You Must 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 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 **Reason**: ____________________________

***Fee required $14 10 or fewer pgs/$.50 pg 11-40/$.33 40+**

? other (specify)_____________________________________

***If you need records for an upcoming appointment, please note the date:** ______________________

This authorization ends: ? on (date) __________________
? when the following event occurs ______________________________________

II. <u>My Rights</u>

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 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.)

****If your address/phone has changed please update:**____