Northside Family Medicine, P.C.

12207 Pecos St. Suite 800
Westminster, CO 80234
(303) 428-8536
Fax (303)427-4015

Authorization to Release My Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information it not a health plan or healthcare provider then the released information may no longer be protected by federal privacy regulations.

Patient Name:____Previous Name:________________________________

ID Number or DOB______________________________________
Persons/Organizations providing the information Northside Family Medicine, PC 12207 Pecos St. Suite 800 Westminster, CO 80234 (303) 428-8536 Fax (303)427-4015

Persons/Organizations Receiving the Information – Name __________________________ Address_________________________
Phone _________________________ Fax_____________________

Specific Description of Information (Include dates or date range desired) Dates ___________________________
____ All Records for that Date Range; ____ Only Lab information; _____ Only Doctor visits; ____
____ Only radiology information Other__________________________

(Check any that may apply)
***Exclude the following information:___ 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.

What is the purpose of disclosure? ____ Change of Doctors ____ Follow up after visit or treatment
____ Patient Requested
I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I can get a copy of this form after I sign it.

I understand that this authorization will expire on ___/____/____ in one year or if patient is a minor when patient becomes an adult or in one year whichever is first.

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 understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I may revoke this authorization in writing. If I do, it will not affect my actions already taken by the above named practice based upon the authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are: Write a letter to the office or come in to the office and sign a letter.

Signature of the Patient or Patient's Representative ____

Date_____________________________
Printed Name of patient's representative _____________________________

Relationship to the patient ___ self or ____