Women's Wellness Center
9998 Dransfeldt Rd
Parker, CO 80134
Ph#303-841-5266 Fax# 303-841-7590

Authorization to Use or Disclose My Health Information

Patient name: _____ Date of birth: _____ Phone # _____

I. Records from: **Records to:**

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Ph #: _____ Ph #: _____

Fax#: _____ Fax#: _____

II. My Authorization

I request and authorize this transfer and release of my medical record to and from the medical practices listed above. I specifically give permission to release the information regarding the following conditions (check all applicable):

- ☐ All Records *(including records relating to mental healthcare, communicable diseases, HIV/AIDS, and treatment of alcohol or drug abuse).*
- ☐ I authorize the release of my complete health record with the exception of the following information: (***Indicate by Initialing***).
  _____*Mental health records* _____*Communicable diseases (including HIV and AIDS)* _____ *Alcohol/drug abuse treatment*
- ☐ Laboratory/Pathology Records
- ☐ Radiology Reports
- ☐ Immunization Records
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s):_____ to _____
- ☐ Other: _____

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

- ☐ At my request/For health care
- ☐ For payment/insurance
- ☐ Other(specify)_____
  _____
  _____
- ☐ For Payment/Insurance
- ☐ Changing Doctor's

I have the right to revoke this authorization by written notice to the Healthcare Provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires one year from the above date unless I specify an expiration date: _____

This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS), OR HUMAN IMMUNODEFICIENCY VIRUS (HIV) RELATED INFORMATION only if I place my initials on the appropriate lines in section II. In the event the health information described below includes any of these types of information, and I initial the appropriate lines in section II, I specifically authorize release of such information to the person indicated in section I.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Patient or legally authorized individual signature Date

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

(Please Note: There may be a charge for the copying of records) In Accordance with Chapter 2, Part 5, sections 5.2.3.4 of the Colorado Regulations of Health Facilities, the cost of this information cannot exceed $16.50 for the first 10 or fewer pages and $.75 per page for pages 11 through 40, and $.50 per page after 40 pages. Actual postage or shipping costs and applicable sales tax, if any, may be charged. We will not be able to process your request until the following payment is received.