Forum Family Medicine, PC

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below:

Patient Name_____ **Birth Date**_____ **SSN**_____

Address_____ **Telephone**_____

I AM REQUESTING RECORDS FROM: _____ **Doctor**_____
Name of Office

Phone_____ **Fax**_____ **Email**_____
REQUIRED ***REQUIRED***

Address_____

PLEASE SEND RECORDS TO:

FORUM FAMILY MEDICINE, PC
14001 E. ILIFF AVENUE STE. 109
AURORA, CO 80014

Purpose of Request_____

Please disclose the following information (please circle):

Entire Medical Record	Immunization Record
Physicians Notes	Daycare Forms
Lab Results	Sports Forms
X-Ray Reports	Camp Forms
Return to Work Authorization	Other: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavior or mental health services or treatment for alcohol and drug abuse.
Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.
Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.
Other Rights: I understand that I may refuse to sign this authorization and that it is strictly voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I may inspect and obtain a copy of the information to be used or disclosed, for a reasonable copy fee of $45.00 if I ask for it.
Expiration: Unless otherwise revoked, this authorization will expire on _____ (Max. 6 months)

Signature of Patient or Guardian_____ **Date**_____

Relationship to Patient_____