Colorado Center for Arthritis & Osteoporosis LLC

CCAO:
Phone: 720-494-4700
FAX: 720-494-4706

Authorization for Release of Medical Information – Initiated by Patient

Patient Name: _____ **Date of Birth:** ___/___/_____

I authorize Colorado Center for Arthritis and Osteoporosis (CCAO) to use or disclose the following protected health information to:

Name: _____ Phone: _____

Address: _____ Fax: _____

_____

Information to be disclosed:

- ☐ Entire medical record
- ☐ Office notes
- ☐ Labs
- ☐ Imaging
- ☐ Problem/medicine/allergy lists
- ☐ Other: _____

Dates to be Disclosed:

- ☐ Last 12 months

Other: _____

Purpose of Disclosure (Choose ONE):

- ☐ Copy for patient
- ☐ Copy for PCP
- ☐ Copy for other doctor
- ☐ Transfer to other rheumatologist
- ☐ Insurance
- ☐ Legal
- ☐ Other: _____

Redisclosure of Health Information:

I understand that the parties disclosing and receiving this health information may not redisclose it without obtaining another authorization from me, unless the disclosure is specifically required or permitted by law. I understand that any disclosure of information carries with it the potential for an unauthorized Redisclosure and the information may not be protected by federal confidentiality rules.

Patient Rights: I understand that:

- I can see and copy the health information described above and that I will receive a copy of this authorization form after I sign it.
- I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.
- I can revoke this authorization by writing to CCAO at any time, but my revocation will not apply to the information that has already been disclosed or used in response to this authorization.

Expiration of Authorization: Unless revoked, this authorization will remain active indefinitely.

Form of Delivery (Choose only ONE) -

<u>For Personal Use ONLY</u>:

- ☐ Secure E-mail
  E-mail address:_____
  Password: _____
- ☐ CD – picked up by patient
- ☐ CD – mailed

<u>For Personal & Other Use</u>:

- ☐ Fax
- ☐ Paper copy – picked up by patient
- ☐ Paper copy – mailed

I have reviewed and understand this authorization to Disclose Protected Health Information. I affirm that it accurately reflects my wishes.

_____ ____/_____/_____ _____

Signature Date Relation (if not patient)

Copy given to signer: ___/___/_____ Initials: _____

Office Use Only:
Authorization received by: ___/___/_____ Initials _____