

PLEASE FAX THIS FORM TO YOUR FORMER PHYSICIAN/PROVIDER



Spruce Street Internal Medicine, LLC
2575 Spruce Street, Boulder, Colorado 80302

303-449-3594

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

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

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Telephone number: _____

Address: _____

Please send my records to:

Spruce Street Internal Medicine, LLC
2575 Spruce Street, Boulder CO. 80302

Purpose of request: _____

Treatment dates: _____

The following information is to be disclosed:

_____ Physician notes _____ Lab Results _____ Complete Record
_____ MRI scans _____ X-rays
_____ 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 behavioral or mental health services or treatment for alcohol and drug abuse.

REDISCLOSURE: I understand that any disclosure of information carries with it the potential for redisclosure and that the information 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 authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

EXPIRATION: Unless otherwise revoked, this authorization will expire on the following date, event, or condition (If you do not specify a date, event, or condition, this authorization will expire in six months).

SIGNATURE OF PATIENT: _____

DATE: _____

If signed by legal representative, relationship to patient: _____