DERMATOLOGY & LASER CENTER at Harvard Park

AUTHORIZATION FOR DISCLOSURE OF MY HEALTH INFORMATION

You may return this form to us by mail, fax or email.

950 E. Harvard Ave. Suite 440, Denver, CO 80210 **Phone: 303-744-2704** **Fax: 303-744-3244**

Medical Records Email: Amanda.stanley@leavittmgt.com

Patient Name :_____ **Date Of Birth:**_____

I Authorize You To Obtain My Records From:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

I Authorize You To Release My Records To:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

This Authorization Expires On:_____**(Cannot Be Longer Than 1 Year)**

1. **I Authorize The Following:**

____All my health information including but not limited to AIDS/HIV and other communicable disease information, behavioral health care/psychiatric care, alcohol and /or drug abuse treatment if any, unless specifically excluded.
_____

___My health information relating to the following treatment or condition: _____

___My health information related to the dates: _____

2. **My Rights:**

I understand I do not have to sign this authorization in order to get health care benefits treatment, payment or enrollment, except 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 I may revoke this authorization in writing at any time. However, I understand that revocation is not effective to the extent that my physician has relied on the use or disclosure of the health information or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest the claim. Two ways to revoke this authorization are to fill out a revocation form available from the office, or write a letter to the office. Once the office discloses health information, the person or organization that receives it may re-disclose it, as privacy laws may no longer protect it. I understand that if this office has requested this authorization, I have the right to receive a copy of it.

_____ _____
Patient Or Other Legally Authorized Signature Date

_____ _____
Printed Name Of Above Signature Relationship (If Other Than Patient)