SoCO Primary Care Clinic

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:	Date of Birth:	Last 4 of Social Security Number:
Address:	City, State, Zip Code	Phone Number:

I hereby authorize the facility listed below to disclose/release the Protected Health Information specified in this request to the organization, facility or person named below.

Release **FROM**	Release **TO**
Name of Facility:	Name of Facility/Organization/Person: SoCO Primary Care Clinic
Address:	Address: 1310 Fortino Blvd. Ste. D Pueblo, CO 81008
Phone/Fax:	Phone/Fax: (719) 582-1898 Fax: (719) 621-4098

Purpose of Disclosure: O Continuation of medical care O Personal Use O Legal O Insurance O Disability

O Other (Please Specify)_____

Information to be Disclosed: O Entire Medical Record O Office Notes/Treatment Plan O Lab/Imaging Results

O All Billing Records

Dates of Treatment: O Most Recent Year O All Dates O Other (Specify)_____

IF ANY OF THE FOLLOWING INFORMATION IS TO BE DISCLOSED, CHECK ALL THAT APPLY:

O Alcohol/Drug Addiction Treatment O Sexually Transmitted Disease Treatment O Mental Health O HIV/AIDS Treatment

I understand that my express consent is requested to release any health care information relating to testing/diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, and drug/alcohol abuse.

I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. To revoke an authorization, I will write a letter to the facility/provider.

I understand that once health information I have authorized to be disclosed reaches the recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

I understand I do not have to sign this authorization to obtain health care benefits (treatment, payment, or enrollment). However my signature is required to receive health care when the purpose is to create health information for a third party.

This authorization will expire 1 year from the date signed unless another date is specified here _____. A copy or fax of this authorization shall be counted true and valid as original.

Signature of Patient/Guardian_____ **Date:**_____

Relationship to Patient_____ **Patient Printed Name**_____