Authorization to Disclose Health Information

Patient Name:_____ Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

_____

Address:_____

3. The type and amount of information to be used or disclosed is as follows:

a.	Problem list	☐	
b.	Medication list	☐	
c.	List of allergies	☐	
d.	Immunization record	☐	
e.	Most recent history and physical	☐	
f.	Laboratory results	☐	From (date) _____ to(date) _____
g.	X-ray and imaging reports	☐	From (date) _____ to(date) _____
h.	Consultation reports	☐	(doctors name)_____
i.	Entire medical record	☐	
j.	Other	☐	_____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health service, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Small World Pediatrics
332 S. Orchard Springs Dr. #150
Pueblo West, CO 81007
719 253-7640 Fax 719 253-7644

Continuing medical care ☐ or other:_____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the entity which was originally authorized to disclose information. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to any insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I do not specify, this authorization will expire in six months.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager, Small World Pediatrics.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness