Authorization To Use Or Disclose Protected Health Information

As required by federal Privacy Regulations, we may not use or disclose your protected health information without your authorization, except as provided in our Notice of Privacy Practices.

WISDOM HEALTH
Caring for Seniors
phone 303-938-1110
fax 303-938-1145
350 Ponca Place
Suite 250
Boulder, CO
80303

Patient Name _____

Address _____

_____

Date of Birth _____

I authorize the office of _____ and any of its employees to use or disclose my Patient Health Information to **Wisdom Health**, for the specific purpose of establishing care with Dr. _____ at this practice.

Patient Health Information authorized to be disclosed:

Recent labs, radiology, problem list, immunization records, health maintenance screening results, and recent progress notes

I understand that once the information has been disclosed by your office it is no longer under your control.
I understand I have the right to:

1. Revoke this authorization by sending written notice to your office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that whether or not I provide authorization to use or disclose protected Patient Health Information it will not condition my treatment, payment, or eligibility for benefits.

_____

Patient Signature Date

This authorization will remain in effect through _____