Authorization for the Use or Disclosure of Protected Health Information

Primary Care Partners, PC
3150 N. 12th Street
Grand Junction, CO 81506

As required by the Health Insurance Portability and Accountability Act of 1996
Primary Care Partners, PC

may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

AUTHORIZATION SECTION

I, _____ Phone Number: _____
Print name

hereby authorize the <use / disclosure / use and disclosure> of the following health information that pertains to me

☐ All medical records: Medical testing, treatments, medicines, any notes doctors make about you and your health

☐ Psychiatric Records

☐ Limited Records (specify): _____

_____

I authorize the following person (s) to receive these disclosures of my health information:

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Primary Care Partners, PC.
I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire one year from the signing date.

I understand that I am under no obligation to sign this authorization. I further understand that <my ability to obtain treatment, my eligibility for benefits, etc.> will not depend in any way on whether I sign this authorization or not.

I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

_____ _____ _____
Signature Date Account #

REVOCATION SECTION

I hereby revoke this authorization: _____ _____
Signature Date