HIPAA Authorization/Disclosure Form

Patient's Full Name | **Patient's Medical Record Number (as applicable)**

Address | **Patient's Date of Birth**

City, State Zip Code | **Patient's Telephone Number**

I hereby authorize use and/or discloser of the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to be released, origin of information, etc.) as described below.

1. The following specific person/class of person/facility is authorized **to use or disclose** information about me:

   ☐ CU Healthcare Partners @ Belleview Point **OR** person/facility listed below

   Name of Person or Facility

   Address

   City, State Zip Code

2. The following person (or class of persons) **may receive** disclosure of protected health information about me:

   ☐ CU Healthcare Partners @ Belleview Point **OR** person/facility listed below

   Name of Person or Facility

   Address

   City, State Zip Code

3. The specific information and dates of service that should be disclosed is (example: entire medical record, procedure on XX date, etc.):

☐ Entire medical record	☐ Labs	☐ Diagnostic Imaging	☐ OR Reports
☐ Clinic notes from the following dates of service:		☐ Other(please specify):	

4. **UNLESS YOU SIGN HERE**, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *_____
   NO, **DO NOT** DISCLOSE THIS INFORMATION * _____
5. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
6. I may revoke this authorization by notifying **CU Healthcare Partners @ Belleview Point** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
7. My purpose/use of the information is for
   _____.
8. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me:
   _____.
9. The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.
10. I do not have to sign this authorization in order to receive treatment from CU Healthcare Partners @ Belleview Point. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

    CU Healthcare Partners @ Belleview Point

    5001 S. Parker Rd. Suite 215 | Aurora, CO 80015 | 303-315-6200

Patient/guardian must be provided with a signed copy of this authorization form.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING –
By signing, I authorize CU Healthcare Partners @ Belleview Point to use and/or disclose protected health information (PHI) about me as outlined in this form.

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

To be filled out by CU Healthcare Partners @ Belleview Point

_____	_____	_____
Received	**Processed By**	**Renewal Date**