

PREMIER SURGEONS

7780 SOUTH BROADWAY, SUITE 250
LITTLETON, CO 80122
PHONE: (303) 795-3375 FAX: (303) 795-0621

Authorization to Use or Disclose My Private Health Information

Patient's Legal Name: _____ Previous Name (if applicable): _____
Date of Birth: _____ Social Security #: _____ Phone #: _____
Address: _____ Email: _____

I. My Authorization:

You may use or disclose the following Health Information (check all that apply):

- All of my Health Information maintained by Premier Surgeons.
- My Health Information relating to the following treatment or condition: _____
- My Health Information for the date(s): _____
- Other: _____

II. You may disclose this Health Information to:

Recipient's Name / Provider's Name / Organization: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____ Email: _____

■ Patient must also complete an Authorization to Disclose Protected Health Information via Electronic Communication in addition to this release for ANY records to be emailed.

III. Requested Delivery:

- Paper Copy
- Fax
- Email
- Electronic Media, if available (e.g., USB drive)

IV. Purpose of Disclosure:

V. This authorization will expire:

- At my request
- Date: _____

VI. I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken by Premier Surgeons prior to receiving the revocation. I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance.
4. If the Requestor or Recipient is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Act regulations and may be re-disclosed.

Patient (or legally authorized individual) Signature Date Time

Printed Name if signed on behalf of the Patient Relationship to Patient (parent, legal guardian, personal representative, etc.)

For Office Use Only

Received by _____ Date Received _____ Identification Verified _____ Form of Identification _____
Request Completed By _____ Date Request Completed _____