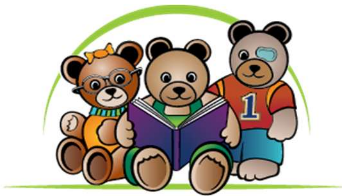

Phone 303-456-9456 Fax 303-467-0145 www.cepcolorado.com

Authorization to Discuss Medical Information

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties described below.

Description of the specific information to be disclosed:

☐ Appointment Date/Time/Location ☐ Diagnosis ☐ Medications

☐ Test Results ☐ Summary of Medical Record ☐ Care Plan

☐ Financial ☐ Glasses/Contacts Prescriptions ☐ Other (please specify)

____

Patient Name: ____

Date of Birth: ____________________

Disclose information to the following party/parties-

Name: ____________________________________ Date of Birth: _______________

Relationship to Patient: ________________________________Phone Number: _______________________

Name: ____________________________________ Date of Birth: _______________

This authorization shall remain in effect from the date signed below until (please check one):

☐ ________________________ (specify expiration date), only valid one year from original signature

☐ Expires one year from date of original signature

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- This authorization is giving Children's Eye Physicians, Colorado Family Eye Center, and Colorado Center for Eye Alignment the right to discuss my medical information with the person/s above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclose by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment)

Signature: ____ Date: ___________________

Relationship to Patient (If signed by personal representative of patient) _________________________