IMMUNOe HEALTH CENTERS

HORIZON PEDIATRICS & PRIMARY CARE

Authorization to Use or Disclose My Health Information

Patient name:_____ DOB: _____ Leaving Practice? Y / N

I. MY AUTHORIZATION *You may use or disclose the following health care information (check all that apply):*

☐ All my health information maintained by:_____

☐ My health information relating to the following treatment or condition:_____

☐ My health information for the date(s):_____

I specifically authorize disclosure of the following conditions (check all that apply):

☐ Drug abuse ☐ Alcohol abuse ☐ HIV/AIDS ☐ Psychological or psychiatric conditions, including psychotherapy notes

You may disclose this health information to:

Name (or title) and organization:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Other (specify)

_____

This authorization ends: ☐ On (date) ____/____/____ ☐ When the following event occurs:

_____

II. MY RIGHTS

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits). However, I do have to sign an authorization form:

To take part in a research study; **OR** To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing. If I revoke this authorization, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:
Fill out a revocation form. The form is available from the office; **OR** Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may be able to redisclose it. Privacy laws may no longer protect it. Pricing is $15.00 for the first 25 pages and .25 for each additional page, not including shipping fees.
IMMUNOe Health Centers and Horizon Pediatrics Primary Care endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO HIE, or cancel an opt-out choice, at any time.

_____ ____/____/____ _____

Patient or legally authorized individual signature **Date** **Time**

_____ _____

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

CENTENNIAL
6801 South Yosemite Street
Centennial, CO 80112
P: 303.773.9000 F: 303.770.1449

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3240 East 104th Avenue
Thornton, CO 80233
P. 303.224.4700 F: 303.425.4392

THORNTON: PEDIATRICS
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