FAMILY PRACTICE ASSOCIATES, P.C.

433 Summit Blvd, #201 ♦ Broomfield, CO 80021

Patient: _____

Date of Birth: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

AUTHORIZATION: I authorize Family Practice Associates to use and/or disclose certain Protected Health Information (PHI) about me to the following individuals. (Please print full name.)

☐ None

Spouse: _____ Family Member: _____
Name and relationship.

Other: _____ Other: _____
Name and relationship. *Name and relationship.*

This authorization includes the release of my ***complete*** medical record for ***past, present and future*** periods unless otherwise specified here: From _____ To _____

Your initials are required to withhold the following information:

___ Alcohol/Drug Abuse Treatment ___ Communicable Diseases ___Mental Health Records ___ Other: _____

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. The medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I direct. I understand that treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization. I may **revoke** this authorization at any time by notifying FAMILY PRACTICE ASSOCIATES, in writing, of my desire to revoke it. The notice will not apply to actions taken by the requesting person/entity prior to the date FAMILY PRACTICE ASSOCIATES receives the request. This authorization is automatically in force for **3 years or until** (date) _____, at which time this authorization expires.

Family Practice Associates, PC 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.

_____ _____

Signature of Patient OR Personal Representative (Relationship) *Date*

REQUIRES PATIENT SIGNATURE:

I acknowledge that I have received a copy of the **NOTICE OF PRIVACY PRACTICES** regarding my health information.

_____ _____

Signature of Patient OR Personal Representative (Relationship) *Date*

I acknowledge that I have received a copy of the **NOTICE OF FINANCIAL POLICIES**.

_____ _____

Signature of Patient OR Personal Representative (Relationship) *Date*

REVISED: 51718