# Authorization for the Disclosure of Protected Health Information for Medical Records.

**Colorado Reproductive Endocrinology**
**4600 E. Hale Parkway, Suite 350**
**Denver, CO 80220**

**Phone: 303-321-7115**
**Fax: 303-321-9519**

As required by the Health Insurance Portability and Accountability Act of 1996 Colorado Reproductive Endocrinology may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

**Authorization Section-**

**I, _____ (print name) hereby authorize the disclosure of the following health information that pertains to me:**

**Medical records**

**I authorize the following persons to make these disclosures of my health information:**

**Colorado Reproductive Endocrinology**
**4600 E. Hale Parkway, Suite 350**
**Denver, CO 80220**

**I authorize the following persons to receive these disclosures of my health information:**

**To:** _____
**Address:** _____
_____
_____

**Patient name:** _____
**Date of birth:** _____
**Maiden name:** _____
**Patient current address:** _____
**SS#:** _____

**I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.**

**I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Colorado Reproductive Endocrinology. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance of this authorization.**

I understand that this authorization will automatically expire_____ (fill in the date you wish this authorization to expire).

**I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.**

**_____( Signature)**
**_____(Date)**

**REVOCATION SECTION**

**I hereby revoke this authorization.**

**_____(Signature) _____(Date)**

**(The fee is $14.00 for the past three years of medical records. Please make checks payable to Colorado Reproductive Endocrinology)**