** Please send this form to your referring doctor"

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, _____hereby authorize the disclosure of the following health information that pertains to me:

Hysterosalpingogram DVD

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

To: _____
Address: _____
_____
_____
Patient name: _____
Date of birth: _____
Maiden name: _____
Patient address: _____
_____
_____
SS#: _____

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

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

I understand that information disclosed pursuant to this authorization may re 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 revocation does not apply to the extent that persons authorized to use 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)