Boulder Dermatology

Allison Elise Morrison, MD., Megan Waite, MD., Berkeley Fial, PA-C, Rachel Collins, PA-C, Todd C Becker, MD., PhD.
3575 Broadway, Boulder, CO 80304 Phone: 303-449-0933 Fax: 303-447-0794
400 S. McCaslin Blvd, Ste. 100, Louisville, CO 80301 Phone: 303-666-5261

Authorization to Use or Disclose My Protected Health Information

Patient Name: ________________________________ **Date of Birth:** ______________________

Previous or other name we may have your information under: ___________________________________

I Authorize Disclosure of the Following (circle) To / From:

Name (or title) and organization: ____

Address: ____

City, State and Zip Code: ____

Fax Number: ____

- All health information maintained by the above named practice
  (Circle "include" or "exclude" for each of the following)
  Include or Exclude: My health information related to drug abuse
  Include or Exclude: My health information related to alcohol abuse
  Include or Exclude: My health information related to psychological or psychiatric conditions
- Information relating to the following treatment or conditions: ______________________________
- Information for the date(s): ____
- Other: ____

You may disclose this health information to / from: **Boulder Dermatology**
3575 Broadway St
Boulder CO 80304
Fax: (303) 447-0794

Purpose of the Disclosure:

- At my request For insurance purposes Other (please specify):
- ____

This authorization ends: On (date): ____

My Rights

I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization to create health information for a third party.

I may revoke this authorization in writing. If I do it will not affect any actions already taken by Boulder Dermatology based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or Legally authorized individual signature: ______________________________ Date: ____________________

Print name and relationship: ______________________________________