CarePoint
Neurosurgery & Spine

303-515-2320
carepointneurosurgery.com

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Care Provider:
CarePoint Neurosurgery, PLLC
799 E. Hampden Ave, Suite 310
Englewood, CO 80113

Patient Name: _____ Date of Birth: _____

Recipient's Name: _____

Recipient's Address: _____ City, State & Zip: _____

This Authorization for Use/Disclosure of Protected Health Information on the following:

☐ Date: _____
☐ Event: _____

(If left blank, this Authorization for Use/Disclosure of Protected Health Information will expire 1 year from the signature date stated below).

☐ Send by facsimile or other electronic means to Recipient at: _____

☐ Send a paper copy by United States Mail, Postage Prepaid to the Recipient's address stated above.

(If left blank, a paper copy will be provided by United States Mail, Postage Prepaid)

Purpose: I authorize the release of my Protected Health Information contained in my designated record set for the following specific purpose:

_____

Authorization for Disclosure of Information: I authorize the disclosure and release of the following Protected Health Information contained in my designated record set (check the applicable boxes below):

☐ All Protected Health Information in my designated record set.

☐ Provider Orders

- ☐ Diagnostic Test Documentation, Assessment and Reports
- ☐ Dictated or written Provider Reports
- ☐ Patient History
- ☐ Provider Notes
- ☐ Intake Forms and Information
- ☐ Medication Records
- ☐ Psychotherapy Notes/Psychiatric Information (Requires Provider Review and Approval)
- ☐ Therapy and Treatment Information
- ☐ Billing Information and Itemized Bills
- ☐ Special forms, letters, or documentation

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information.

_____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned upon this authorization.
3. I may revoke this authorization at any time in writing and delivered to the health care provider at the address stated above, but if I do, my revocation will not have any effect on any actions taken prior to receiving the revocation. Further tails may be found in the Notice of Privacy Practices.
4. If the recipient is not a health plan or healthcare provider, the released protected health information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the protected health information described in this form for a reasonable fee and after a request by me, unless otherwise prohibited by law.
6. I am entitled to receive a copy of this form after I sign it.

I have read the above and foregoing Authorization for Use and disclosure of Protected Health Information and hereby authorize the disclosure of Protected Health Information as stated. A photocopy or electronic copy of my signature shall be effective as an original signature.

If signed by Patient's Representative, print name of Patient's Representatives and relationship to patient:

Patient Representative: _____ Relationship to Patient: _____

_____ _____

Patient/Patient's Representative Signature Date

_____ _____

Provider Signature Date