HIPAA-Compliant authorization for use and disclosure of protected health information (PHI)

Patient Information

Patient Name: _____
Date of Birth: _____
Address: _____
_____
Phone Number: _____

Entity Authorized to Disclose Information

Practice Name: Orofacial Pain Associates of Colorado Springs
Address: 2575 Montebello Dr W, Ste 202
Colorado Springs, CO 80918
Phone: (719) 260-0600
Fax: (719) 264-9235
Email: frontdesk@ofpcos.com

Person/Entity Authorized to Receive Information

Name/Organization: _____
Relationship (if applicable): _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____

Description of Information to Be Used or Disclosed

I authorize the use and/or disclosure of my Protected Health Information (PHI), including (check all that apply):

☐ Complete medical record
☐ Billing and payment records
☐ Treatment notes and clinical records
☐ Diagnostic test results (labs, imaging, etc.)
☐ Appointment history
☐ Insurance information
☐ Other (specify): _____

Exclude the following information (if applicable):

Purpose of Disclosure

☐ At the request of the patient
☐ Continuity of care
☐ Insurance/payment
☐ Legal purposes
☐ Personal use
☐ Other: _____

Expiration of Authorization

This Authorization will expire (check one):

☐ On this date: _____
☐ Upon the following event: _____
☐ One (1) year from the date of signature (default if not specified)

Patient Rights and Acknowledgments

- I understand this Authorization is **voluntary**. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing this Authorization, except as permitted by law.
- I understand I may **revoke this Authorization at any time** by submitting a written request to the provider listed above, except to the extent that action has already been taken in reliance on it.
- I understand that information disclosed pursuant to this Authorization **may be subject to re-disclosure** by the recipient and may no longer be protected by federal privacy regulations.
- I understand I have the **right to inspect or obtain a copy** of the information to be used or disclosed.
- I acknowledge that I have been given the opportunity to receive a copy of this signed Authorization now or at any time in the future upon request.

Colorado-Specific Provisions

- This Authorization complies with the **Colorado Medical Records Act (C.R.S. § 25-1-801 et seq.)**.
- The following information **will NOT be disclosed unless specifically authorized by initialing below**, where applicable:

Initials: _____ **Psychotherapy Notes**
Initials: _____ **Substance Use Disorder Records (42 CFR Part 2)**
Initials: _____ **HIV/AIDS-Related Information**

8. Signature

Patient or Personal Representative Name: _____

Signature: _____

Date: _____

If signed by Personal Representative, describe authority:

For Office Use Only

Date Received: _____
Processed By: _____

Notice: This Authorization is intended to comply with 45 CFR §164.508 and applicable Colorado law and is suitable for audit and compliance review.