

## Boulder Endocrinology Associates

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### Authorization to Use or Disclose Protected Health Information

I hereby authorize use or disclosure of the named individual's health information as described below:

Name:	Date of Birth:	Social Security Number:
Address (Street, City, State, Zip Code):		Telephone:
<input type="checkbox"/> Information may be released <i>to</i> Boulder Endocrinology Associates (address above) <input type="checkbox"/> Information may be released <i>by</i> Boulder Endocrinology Associates (address above)		
<input type="checkbox"/> Information may be released <i>to</i> the following individual or organization: <input type="checkbox"/> Information may be released <i>by</i> the following individual or organization: Name: _____ Phone (if known): _____ Address: _____ Fax (if known): _____ City/State/Zip: _____		
Dates of service to be copied: <input type="checkbox"/> From _____ To _____ <input type="checkbox"/> All records	Purpose of Request: <input type="checkbox"/> Medical Treatment <input type="checkbox"/> Other: _____	
The following information is to be disclosed: <i>(Please check one box for each item)</i> Yes No <input type="checkbox"/> <input type="checkbox"/> Physician Notes <input type="checkbox"/> <input type="checkbox"/> Lab results <input type="checkbox"/> <input type="checkbox"/> Radiology (x-ray) reports <input type="checkbox"/> <input type="checkbox"/> Cardiac Studies <input type="checkbox"/> <input type="checkbox"/> Complete Record <input type="checkbox"/> <input type="checkbox"/> Other		
Sensitive information: I understand that the information in my record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.		
Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.		
Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.		
Other rights: (a) I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. (b) I understand that I may inspect or obtain a copy of the information to be used or disclosed.		
Expiration: Unless otherwise revoked, this authorization will expire on the following day, event, or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in six months.)		
Signature of patient or legal representative:		Date:
If signed by legal representative, relationship to patient:		