

**Authorization for Corneal Consultants of Colorado, P.C. to Use or Disclose My Health Information**

Patient name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_

**I. My Authorization**

**You, Corneal Consultants of Colorado, P.C., may use or disclose the following health care information:**

- All my health information maintained by you
- My health information relating to the following treatment or condition: \_\_\_\_\_
- My health information for the date(s): \_\_\_\_\_
- Other: \_\_\_\_\_

**You may disclose this health information to:**

Name (or title) and organization \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Reason(s) for this authorization (check all that apply):**

- at my request
- other (specify) \_\_\_\_\_
- check here only when Corneal Consultants of Colorado, P.C., will get something of value for providing health information for marketing purposes

**This authorization ends:**  on (date) \_\_\_\_\_  
 when the following event occurs \_\_\_\_\_

**\*\*Please allow 72 hours for processing\*\***

**II. My Rights**

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Corneal Consultants of Colorado, P.C., at the address provided below. If I do, it will not affect any actions already taken by Corneal Consultants of Colorado, P.C., based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

- 8381 SouthPark Lane, Littleton, Colorado 80120 303 730-0404 FAX 303 730-6163

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

\_\_\_\_\_  
Patient or legally authorized individual signature Date Time

Patient is unable to sign because of: \_\_\_\_\_  
Age of minor or reason for patient's inability to sign

\_\_\_\_\_  
Printed name if signed on behalf of the patient Relationship & Authority (parent, legal guardian, personal representative, etc.)

