Advanced Dermatology
Skin Cancer and Laser Surgery Center, P.C.

Authorization to Use, Disclose or Request My Health Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. Patient's Authorization: You may use or disclose the following health care information (check all that apply):

- ☐ All my health information maintained by the above named practice
- ☐ 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: or Request from: (Circle whichever applies)

Name (or title) and organization_____

Address: _____City _____State _____Zip_____

Telephone: _____ Fax: _____

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

☐ At my request
☐ Other (specify):_____

This authorization ends: ☐ on (date) _____ *(One year from the date signed unless specified for an earlier time)*
☐ When the following event occurs: _____

II. Patient's Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an 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 in writing. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Please write a letter to the office if you wish to revoke this authorization.

Office Locations:				
Aurora	**Centennial**	**Frisco**	**Castle Rock**	**Evergreen**
1390 S Potomac St. Suite 124 Aurora, CO 80012	12645 E Euclid Drive Centennial, CO 80111	710 Summit Blvd., Suite 102 P.O. Box 4005 Frisco, CO 80443	2352 Meadows Blvd. Suite 220 Castle Rock, CO 80109	30960 Stagecoach Blvd Suite W140 Evergreen, CO 80439
Fax: 303-368-9791	Fax: 303-493-1915	Fax: 970-668-9654	Fax: 303-493-1915	Fax: 303-670-7067

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 Time

_____ _____
Patient Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)