**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________________________________________Telephone: _______________

☐ Mail Address: _______________________________City ____________________State ________Zip_______

☐ Fax: ____________________ ☐ In-person Pick up: ______________________

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. | 12645 E Euclid Drive | 710 Summit Blvd., | 755 Maleta Lane, | 30960 Stagecoach Blvd |
| Suite 124 | | Suite 102 | Suite 201 | Suite W140 |
| Aurora, CO 80012 | Centennial, CO | P.O. Box 4005 | Castle Rock, CO | Evergreen, CO 80439 |
| | 80111 | Frisco, CO 80443 | 80109 | |
| Fax: 303-368-9791 | Fax: 303-493-1915 | Fax: 970-668-9654 | Fax: 303-284-9736 | Fax: 303-674-6055 |

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.)