Mountain West Dermatology, P.C.
2655 Little Bookcliff Drive, Grand Junction, CO 81501
Phone: (970) 242-7273 Fax: (970) 241-2878

Authorization to Use or Disclose My Health Information

Patient's name: _____ **Date of Birth** ___/___/___/

Previous Name/Alias _____

I. My 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: _____

I specifically authorize disclosure of the following conditions (check all that apply):

- ☐ Drug abuse
- ☐ Alcohol abuse
- ☐ HIV / AIDS
- ☐ Psychological or psychiatric conditions, including psychotherapy notes.

You may disclose this health information to:

Name (or title) or organization: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

This authorization ends: on (date) _____

or when the following event occurs _____

My Rights I understand I do not have to sign this authorization form 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 to to 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 used upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

1. Fill out a revocation form. The form is available from this office.
2. Write a letter to the office.

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

_____ _____ _____
Patient or legally authorized individual signature Date Time

_____ _____
Printed name if signed on behalf of the patient Relationship

Messages (Optional)
If unable to reach me:

- ☐ You may leave a detailed message

_____ _____ _____
Patient or legally authorized individual signature Date Time