Surgical Consultants of Aurora, P.C.
1421 S Potomac St., Suite 220, Aurora, CO 80012 Phone 303-337-5600 Fax 303-337-7734

Authorization for Use or Disclosure of Protected Health Information

Patient Name: ____ **DOB:** ____________________

Information to be Used or Disclosed: ____
____
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Circle Include or Exclude for each of the following:

❑ Check here if this does not apply.
Include or Exclude: Health information related to drug abuse.
Include or Exclude: Health information related to alcohol abuse.
Include or Exclude: Health information related to HIV/AIDS.
Include or Exclude: Health information related to psychological conditions.

Reason for this Authorization:
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Persons Authorized to Disclose Information

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____
____

Persons to Whom Information May Be Disclosed

____
____
____

Expiration Date of Authorization
This authorization is effective through ________________________ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization
I understand I do not have to sign this authorization in order to obtain health care. I may revoke or terminate this authorization by submitting a written request.

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

______________________________________ ______________________________________
Signature of Patient Signature of Patient Representative

______________________________________ ______________________________________
Date Relationship of Patient Representative