

**Advanced Pediatric Associates**  
**Authorization to Use or Disclose Health Information**

Patient Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_

**My Authorization**

You may use/disclose/transfer the following health care information (check all that apply)

- All health information maintained by Advanced Pediatric Associates
- All health information maintained by \_\_\_\_\_
  
- I specifically authorize the release of information regarding the following conditions:
  - Drug Abuse (if any)                       Substance Abuse (if any)
  - AIDS/HIV (if any)                               Psychological/Psychiatric Conditions (if any)
- Other: \_\_\_\_\_

**You may disclose this information to:**

Name or Organization: \_\_\_\_\_

Address: \_\_\_\_\_

**The reason for this authorization is:**

- Permanent transfer of records                       Copies for my personal files
- Copies for specialist/school/daycare                       Other \_\_\_\_\_

**Acknowledgement of Charges for Copying of Records**

*I acknowledge that in accordance with the Colorado Department of Public Health and Environment a fee may be charged for copies of medical records. The charge is \$14.00 for the first ten or fewer pages and 30 cents for every additional page. Actual postage may also be charged if applicable. There is no charge for physician to physician record transfers.*

**My Rights**

*I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing or by completion of a revocation form available from the practice. 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. Once the practice discloses health information the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.*

***This authorization expires six months from the date of signature or on \_\_\_\_\_.***

***A copy of this authorization may be utilized with the same effectiveness as the original.***

**Signature**

\_\_\_\_\_  
*Patient or legally authorized signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed name if signed on behalf of the patient*

\_\_\_\_\_  
*Relationship (parent, legal guardian)*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*Phone*