

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO COLORADO PAIN EXPERTS

*Patients Name: _____ * Date of Birth: _____

*I hereby authorize _____

* Phone: _____ * Fax: _____

or it's agent(s) to disclose my health information as described in this authorization to Colorado Pain Experts
Office 970-473-7900 Fax 970-473-7901***Choose Physicians Location**

___ Greeley: 7251 W 20th Street, Unit K Greeley, CO 80634

___ Loveland: 1647 E 18th Street Loveland, CO 80538

The health information is being disclosed for the following purpose: (check appropriate box):** Change of Insurance or Physician Continuation of CareHealth information to be disclosed: (check appropriate box)** 2 years prior from last date seen by the healthcare provider The following health information (be specific):

*I understand I may revoke this Authorization at any time by sending written notice of my revocation to CPE's health information management department. I understand that my revocation will not be effective to the extent the healthcare provider has taken action in reliance on this Authorization. Unless revoked sooner, this Authorization will expire on the following date, event, or condition. If no date, event, or condition is written, this authorization will expire 1 year from the date signed. A photocopy of this Authorization will expire 1 year from the date signed. A photocopy of this Authorization will be considered effective and valid as the original.

**I understand that the health information authorized to be disclosed under this Authorization may include information regarding drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.*

*I understand that CPE may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that the Recipient may redisclose the records and that the records may no longer be protected by Federal privacy regulations.

***I have read this Authorization and I acknowledge that I am familiar with and fully understand its terms and conditions.**

X _____

Signature of Patient / Parent / Guardian or Authorized Representative

Date

(Guardian or Authorized Representative must attach documentation of such status.)

Printed name of Authorized Representative and Telephone Number_____
Relationship / Capacity to