Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact the office at 303-935-3465.

Patient's Consent

Name_____________________________________

Address___________________________________

City______________________________________, State_______, Zip___________

Telephone_________________________________

I,____________________________, have read your Notice of Privacy Policies and I consent to your use of my PHI for purposes of healthcare operations, treatment and payment activities.

If this consent is signed by a personal representative on behalf of the patient, complete the following.

Personal Representative's Name.__________________________________

Relationship to the patient._______________________________________

Patient's Revocation.
By signing below, you revoke your above consent for use to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any or any of our prior actions while acting under your consent.

Signature____________________________________ Date___________________

This information is intended as advisory in nature and should not be considered as legal advise nor is it a substitute for legal advice. This information does not constitute technical information system/ security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.