CASTLE ROCK
PEDIATRICS

1001 S. Perry St. Suite 101B, Castle Rock, CO 80104
Authorization to Use/Disclose My Child(ren)'s Health Information

Patient Name: _____ Date of Birth: _____

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I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my children's health information maintained by the following practice:
Name: _____

Address: _____

_____

(Circle to include or to exclude for each of the following.)

Include or Exclude: My child(ren)'s health information related to drug/alcohol abuse.

Include or Exclude: My child(ren)'s health information related to HIV/AIDS.

Include or Exclude: My child(ren)'s health information related to psychological or psychiatric conditions including psychotherapy notes.

☐ My child(ren)'s health information relating to the following treatment or condition:
_____

☐ My child(ren)'s health information for date(s):_____

☐ Other: _____

You may disclose this health information to: Castle Rock Pediatrics, PLLC
1001 S. Perry St. Ste. 101B
Castle Rock, CO 80104
Phone: (303) 688-2228 Fax: (303) 663-0640

Reason for this authorization (check all that apply):

☐ At my request.

☐ Other (please specify): _____

This authorization ends:

☐ Date _____

☐ When the following event occurs:_____

II. My Rights

I understand I do not have to sign this authorization in order to get health benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive heath care when the purpose is to create health information for 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 based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. The two ways to revoke this authorization are:

- Fill out a revocation form, available from the office
- Write a letter requesting revocation 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 Relationship (parent, legal guardian, etc.)