

Authorization for Disclosure of Information

To authorize the disclosure of medical or billing information to family members or others, please complete this form indicating who you would like your information shared with and what information you would like to disclose.

Patient Name: _____ Date of Birth: _____

Information I authorize to be disclosed:

- Appointment Date/Times
- Medical records
- Billing Information
- Mental Health
- HIV and Aids Information
- Alcohol/Drug Information

I hereby authorize Castle Rock Hospital District to disclose my personal health information that is checked above to the following individuals:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____
4. _____ Relationship: _____

I understand that:

This Release of Information will remain in effect until terminated by me in writing.

I may revoke this authorization at any time in writing.

This authorization is giving Castle Rock Hospital District the right to discuss my medical and billing information with the individuals listed above.

Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPAA.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness printed name: _____