Azmi Farag, MD, P.C.

Authorization to Use or Disclose My Health Information

Patient Name: _____ Date of Birth: _____

Previous Name: _____ S.S.#: _____

I. My Authorization

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

All my health information maintained by the above named practice
(Circle include or exclude for each of the following)

Include or Exclude: My health information related to drug abuse
Include or Exclude: My health information related to alcohol abuse
Include or Exclude: My health information related to HIV/AIDS
Include or Exclude: My health information related to psychological or psychiatric conditions, including psychotherapy notes

My health information relating to the following treatment or condition: _____
My health information for the date(s): _____
Other: _____

You may disclose this health information to: Name (or title) and organzation: _____

Address: _____ City _____ State _____ Zip _____

Reasons for this authorization (check all that apply):

At my request
Other (specify) _____
_____
_____
_____

Health Information coming from:

Azmi Farag MD PC
5390 N. Academy Blvd #220
Colorado Springs, CO 80918
719-268-9000 Fax: 719-268-6687

This authorization ends: on (date) _____
or when the following occurs _____
_____
_____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form to take part in a research study, or to receive health 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 way to revoke this authorization is to write a letter to this office.

Once the office discloses the health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature | Date | Time

_____ _____
Printed Name if signed on behalf of the patient | Relationship to patient (parent, legal guardian, representative, etc)