HIPAA Authorization for Sharing and Use (To and From)

Please address this document and all mail to:

Administration Office
Colorado Neurogeriatrics
Andrew Schechterman PhD LLC
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Centennial, Colorado, 80112

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Authorization for Release, Sharing and Use of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I authorize and hold harmless Andrew Schechterman PhD LLC Colorado Neurogeriatrics and ________________________________to share the protected and confidential health information described below.

I understand that this authorization does not protect from misinterpretation of record, secondary release of the record and/or other privacy risks, implications or consequences not mentioned within.

Unless otherwise noted, this release authorizes two-way communication for the effective period of time indicated below.

2. Effective Period

This authorization is for one of following:

☐ From (date) ______________ to (date)______________.

☐ For the last twelve (12) months.

☐ For the last ______ healthcare visits.

3. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol and/or drug abuse).

- OR -

☐ I authorize the release of my health record, with the exception of the following information:

☐ Mental healthcare
☐ Communicable diseases

☐ Alcohol and/or drug abuse treatment
☐ Other (please specify):
☐ Other (please specify):
☐ Other (please specify):

4. This information may be used by the above persons for healthcare consultation or treatment, billing or claims payment, or other purposes as I may direct.

5. I understand that I have the right to revoke this authorization, by doing so in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity that has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my healthcare, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information disclosed and used pursuant to this authorization may be secondarily disclosed by one of the parties and may no longer be protected by State or Federal laws.

Signature of Patient (or Legal POA) ______________________________

Printed name of Patient (or Legal POA) ___________________________

Signature of Witness ____

Printed name of Witness _______________________________________

Date signed___________________

Please contact our office (303-242-3510) with any questions, comments or requests per this medico-legal document.