BROOMFIELD PEDIATRICS & INTERNAL MEDICINE
3301 W. 144th Ave., Ste. 200
Broomfield, CO 80023
303-438-5522
303-438-5686 Fax

Patient Authorization for Practice to Release
Protected Health Information to Third Parties

By signing this authorization, I authorize Broomfield Pediatrics & Internal Medicine to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Broomfield Pediatrics & Internal Medicine to use or disclose to _____ the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.)_____
_____
_____
_____

This authorization will expire on _____.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Broomfield Pediatrics & Internal Medicine has acted in reliance upon this authorization. My written revocation must be submitted to Broomfield Pediatrics & Internal Medicine at 3301 W 144th Ave #200, Broomfield, CO 80023.

Signed by: _____ _____
Signature of Patient or Legal Guardian *Relationship to Patient*

_____ _____
Patient's Name *Date*

_____
Print Name of Patient or Legal Guardian